

CAFETERIA REIMBURSEMENT REQUEST
FOR MEDICAL, DENTAL, VISION, OR ORTHODONTIA EXPENSES

EMPLOYED BY: Cut Bank Schools

RETURN TO:

NAME OF EMPLOYEE: _____

NORTHWEST ADMINISTRATORS
800 9TH STREET SOUTH
PO BOX 3105
GREAT FALLS, MT 59403

EMPLOYEE I.D. # (Social Security) _____

EMPLOYEE'S ADDRESS _____

FAX: (406) 761-0619
TELEPHONE (406) 453-7026
1-800-406-1027

INDICATE IF THIS IS A CHANGE OF ADDRESS

I HEREBY SUBMIT THE FOLLOWING TO BE PAID FROM MY CAFETERIA
MEDICAL, DENTAL, VISION OR ORTHODONTIA EXPENSES FOR:

CLAIM #1 _____ (Name of Patient)
_____ (Name of Doctor or Provider)
_____ (Date(s) of Service)
_____ (Amount to Be Paid From Cafeteria Fund)

CLAIM #2 _____ (Name of Patient)
_____ (Name of Doctor or Provider)
_____ (Date(s) of Service)
_____ (Amount to Be Paid From Cafeteria Fund)

CLAIM #3 _____ (Name of Patient)
_____ (Name of Doctor or Provider)
_____ (Date(s) of Service)
_____ (Amount to Be Paid From Cafeteria Fund)

DOCUMENTATION OF EXPENSES.

Any participant applying for reimbursement under this plan- shall submit to the Administrator all hospitalization, doctor, optical, or other medical bills. These bills must list date(s) of service, name of provider, description of services(s), name of provider, description of service(s) rendered and name of patient. Photocopies of itemized statements will be accepted.

OTHER INSURANCE

Reimbursement under this plan shall be made by the Company only in the event and to the extent that such reimbursement or payment is not provided for under any insurance policy or policies, whether owned by the corporation or by the participant, or under any other health or accident plan. In the event there is such a policy or plan in effect, providing for coverage under such policy or plan, the corporation shall be relieved of any liability hereunder.

I CERTIFY THESE BILLS ARE ELIGIBLE UNDER MY CAFETERIA PLAN.

SIGNATURE
OF EMPLOYEE _____

HOME PHONE: _____
WORK PHONE _____