

**CAFETERIA REIMBURSEMENT REQUEST  
FOR CHILD CARE EXPENSES**

EMPLOYED BY:

\_\_\_\_\_  
(Name of Company or Firm)

NAME OF EMPLOYEE:

EMPLOYEE I.D. # (Social Security #):

EMPLOYEE'S ADDRESS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RETURN TO:

**BERN & PUGH, INC.  
1 FIFTH STREET NORTH  
GREAT FALLS, MT 59401**

**FAX: (406)727-4979  
PHONE: (406)727-4969  
1-800-406-4097**

**claims@bernpugh.com**

**INDICATE IF THIS IS A CHANGE OF ADDRESS**

I HEREBY SUBMIT THE FOLLOWING TO BE PAID FROM MY CAFETERIA PLAN

**DEPENDENT CARE EXPENSE FOR:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Name of Dependent)  
(Name of Babysitter/Nursery)  
(Date (s) of Service)  
(Amount to be Paid from Cafeteria Fund)

**DOLLAR AMOUNT MUST BE SPECIFIED**

**DOCUMENTATION OF EXPENSES.**

Any participant applying for reimbursement under this plan shall submit to the Administrator, at least quarterly, all claims for reimbursement. This form must be accompanied by documentation of **Incurred Child Care Expenses. Documentation must show, Dates of Service, Child Care Providers Name, Amount Paid.**

***I CERTIFY THESE BILLS ARE ELIGIBLE UNDER MY CAFETERIA PLAN.***

**SIGNATURE  
OF EMPLOYEE**

\_\_\_\_\_

HOME PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_

**DATE**

\_\_\_\_\_

**THESE ARE REQUIRED**