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 INSURANCE
201 Smelter Ave NW
Great Falls MT 59404

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

claims@berninsurance.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