

**NATIONAL CENTER FOR APPROPRIATE TECHNOLOGY
MEDICAL REIMBURSEMENT PLAN CLAIM FORM**

NAME OF EMPLOYEE:

EMPLOYEE'S ADDRESS:

INDICATE IF THIS IS A CHANGE OF ADDRESS

ATTACH EXPLANATION OF BENEFITS TO THIS FORM.

DOCUMENTATION OF EXPENSES:

Any participant applying for reimbursement under this plan shall submit to Bern & Pugh, Inc. all corresponding Explanation of Benefits. Only amounts applied to the deductible or coinsurance are eligible for reimbursement.

OTHER INSURANCE:

Reimbursement under this plan shall be made by the Administrator 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 Administrator, or by the participant, or under any other health and accident plan. In the event there is such a policy or plan in effect, providing for coverage under such a policy or plan, the Administrator shall be relieved of any liability hereunder. Any amounts paid by National Center for Appropriate Technology that are later paid or reimbursed by any other source need to be repaid to the Plan.

I CERTIFY THESE BILLS ARE ELIGIBLE BENEFITS UNDER NATIONAL CENTER FOR APPROPRIATE TECHNOLOGY'S MEDICAL REIMBURSEMENT PLAN AND HAVE NOT AND WILL NOT BE PAID OR REIMBURSED FROM ANY OTHER SOURCE.

Bern & Pugh, Inc. will automatically process this claim through my Section 125 cafeteria plan. I understand that the information to be disclosed is protected by law and that the same information may be re-disclosed by the recipient and may no longer be protected by the same law(s) that applied in the first instance. I understand that this authorization only applies to the claims attached.

**SIGNATURE
OF EMPLOYEE**

HOME PHONE

WORK PHONE

DATE

RETURN COMPLETED FORM TO:

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

or FAX (406) 727-4679

or EMAIL claims@bernpugh.com