

# DAY CARE REIMBURSEMENT CONTRACT

**You may use this form for automatic reimbursement each month if you are required to pay monthly amounts even when you do not require care due to illness, vacation, etc.**

### Instructions

1. Please fill in all fields legibly. Missing information could cause a delay in processing.
2. Check the box below\* to start a recurring claim or to change or stop an existing claim.
3. It is your responsibility to notify Allegiance of any changes in a timely manner.
4. You can fax your completed form to 1-877-424-3539.

Employer:		Date:	
Employee Name:		Participant ID #:	
<input type="checkbox"/> Start*	<input type="checkbox"/> Change*	<input type="checkbox"/> Stop*	
Dates rates are effective ____ / ____ / ____ to ____ / ____ / ____			
The provider charges \$ _____ per month.			
Dependent(s) for whom care will be provided:			
Provider's Name		Provider's Signature	
Provider's Tax I.D. Number			

Some examples of <b>ELIGIBLE</b> expenses:	Some examples of <b>INELIGIBLE</b> expense:
<ul style="list-style-type: none"> <li>Day Care Centers</li> <li>Elder Care</li> <li>Family Child Care</li> <li>Day Camps</li> <li>Preschool</li> <li>After School Care</li> <li>Nanny / Au Pair</li> </ul>	<ul style="list-style-type: none"> <li>Meals</li> <li>Overnight Camps</li> <li>Diapers</li> <li>Education expenses, including Kindergarten</li> <li>Incidental fees, such as activity fees and field trips</li> </ul>

**Claims are paid with the funds available in your account at the time your payment comes due. Unpaid balances continue to be paid as funds become available.**

**I certify that stated payment amounts are due provider even if absences occur during any billing period.**

**Employee Signature \_\_\_\_\_ Date \_\_\_\_\_**