



PO Box 4346, Missoula, MT 59806
 Phone: (877) 424-3570
 Fax: (877) 424-3539
 www.allegianceflexadvantage.com

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

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 _____