# DAY CARE REIMBURSEMENT CONTRACT

EV01

Allegiance®
a Cigna Company

**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 NAME: | DATE: |
|---|---|
| EMPLOYEE NAME: | PARTICIPANT ID NUMBER: |

☐ Start*  ☐ Change*  ☐ Stop*

Dates rates are effective _____ /_____ /_____ to ______ /______ /______

The provider charges $ _______ per month and TOTAL $ _______ per contract range.

(example $100 per month x 12 months total would be $1,200.00 per contract range.)

Dependent(s) for whom care will be provided:

| Provider's Name | Provider's Signature |
|---|---|
| | |
| **Provider's Tax ID Number** | |
| | |

| Some examples of ELIGIBLE expenses: | Some examples of INELIGIBLE expenses: |
|---|---|
| • Day Care Centers<br>• Elder Care<br>• Family Child Care<br>• Day Camps<br>• Preschool<br>• After School Care<br>• Nanny / Au Pair | • Meals<br>• Overnight Camps<br>• Diapers<br>• Education expenses, including Kindergarten<br>• 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: _______________________

2014

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