HEALTHY DOLLARS

DEPENDENT CARE ACCOUNT CLAIM FORM

PARTICIPANT NAME: _____ **EMPLOYER NAME:** _____

☐ **Check here if address has changed:**

STREET ADDRESS: _____ **CITY, STATE & ZIP:** _____

E-MAIL ADDRESS: _____ **PHONE NUMBER:** _____

Specific Date Reimbursement ** Please fill this out for one time claim reimbursement**

☐ An Itemized Invoice from my service provider showing date of services and amount due.

Service Date	Service Provider Name	Dependent Name	Monetary Amount
		TOTAL AMOUNT REQUESTED TO BE REIMBURSED:	**$**

Continual Reimbursement ** Please fill this out for automatic reimbursement 2 to 3 days after payroll cycle**

SERVICES PROVIDED FOR	
DEPENDENT 1:	AGE:
DEPENDENT 2:	AGE:
SERVICE PROVIDER	
PROVIDER NAME:	
ADDRESS:	
START DATE:	END DATE:

AFFIRMATIVE STATEMENT FROM PROVIDER **Required for Continual Reimbursement only**

I _____ am providing daycare services for the dependents listed above for the dates of service stated for an annual fee of $_____.

PROVIDER NAME: _____ **TIN or SSN:** _____

SIGNATURE: _____ **DATE:** _____

DIRECT DEPOSIT INFORMATION: ☐ **Check here if Banking Information has changed**

Please note this should be your PERSONAL account information NOT your providers account

BANK NAME:	◯ **CHECKING** ◯ **SAVINGS**
ROUTING NUMBER:	
ACCOUNT NUMBER:	

I verify that the information listed above, and the attached information is true and correct. I understand that if any changes regarding the continual payment occur that Healthy Dollars (at the address below) MUST be notified in writing immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible.

PARTICIPANT SIGNATURE: _____ **DATE:** _____

Please send completed forms and documentation to:
Email : Service@healthydollarsinc.com, Fax: 877-687-6921
For Questions, please call 877-900-MYRX (6979).