Revolving Dependent Care Expense Reimbursement Form

Employer Name: ______________________________ Employer Group#: ______________________

Employee Name: ______________________________ SS#: ______________________________

This form, along with a completed and signed Claim Form must be submitted to Paragon Benefits, Inc. to insure proper processing. You must notify Paragon Benefits, Inc. of ANY changes regarding your Dependent Care Provider, such as interruption of service, change in charges, etc. In order for Paragon Benefits, Inc. to process a revolving Dependent Care Claim for you, we require some information form the Dependent Care Provider.

Dependent Care Provider

Answer All Questions and Sign Below

Name of Day Care Center:

Provider Tax ID # or Social Security #:

Name of Individual Day Care Provider:

Telephone Number:
( )

Address:

Amount of Day Care Expense:
$

City/ State/ Zip Code:

Time Period Covered:
From: To:

Name of Dependent(s) Receiving Care:

I certify that to the best of my knowledge, all of the information entered on this form is accurate.

Signature of Day Care Provider: ______________________ Date: __________________

www.paragonbenefits.com