Daycare Reimbursement Contract

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, or complete and save form, login to the portal and file a claim.

Employer Name:	Date:
Employee Name:	Participant ID:

☐ Start*	☐ Change*	☐ Stop*

Dates rates are effective _____ /_____ /_____ to _____ /_____ /_____
(Please make sure dates are within your current Plan Year)

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 Tax ID Number:

Provider's Signature: _____

Some examples of ELIGIBLE expenses:	Some examples of INELIGIBLE expenses:
• Day Care Centers • Elder Care • Family Child Care • Day Camps • Preschool • After School Care • Nanny/Au Pair	• 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 to the provider even if absences occur during any billing period.

Employee Signature: _____ Date: _____

2021