Dependent Care Continual Reimbursement Form

Employee Information	
Employer Name:	
Employee Name:	Social Security #:
Address:	
Phone Number:	
Services Provided For	
Child 1:	Age:
Child 2:	Age:
Child 3:	Age:
Service Provider	
Provider Name:	
Address:	
Start Date:	End Date:

Affirmative Statement from Provider

I ______________________ am providing daycare services the children listed above for the dates of service stated for an annual fee of $____________.

Provider Name:________________________________ TIN or SS: __________________________________

Signature: ____________________________________ Date: ______________________________________

Direct Deposit Information		
Bank Name:		
Account Number:	Checking	Savings
Routing Number:		

I verify that the information listed above and the information attached 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.

____ ___________________________________

Employee Signature Date

PO Box 8592, Essex, VT 05451
Service@healthydollarsinc.com
Phone: 877-900-MYRX (6979) Fax: 877-687-6921