



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 from 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

P.O. Box 12288 Columbus, GA 31917

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