

HEALTHY DOLLARS

CONTINUAL REIMBURSEMENT REQUEST

Employer Name:		
Participant Name:		Social Security #:
Participant Address:		
Home Phone #:		Work Phone #:
Services Provided For		
Name:		Social Security #
Description of Expense:		
Service Provider () Dependent Care () Orthodontia		
Provider Name:		
Address:		
Start Date:		End Date:
Payment Amount: \$	# of Payments:	Total Amount:\$

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.

Participant's Signature

Date

Employer Name: _____

Affirmative Statement From Provider

I, _____ am providing _____ services to _____
for _____.

Dates of Service _____ to _____ Estimated Fees \$ _____ per _____

Name of Provider

Tax ID# or SSN

Signature of Provider

Date