Prodegi
Corporate Benefit Services

CONTINUAL REIMBURSEMENT REQUEST					
EMPLOYEE NAME	POLICY NUMBER		NAME OF EMPLOYER		
EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER	DATE SUBMITTED
CLAIMANT'S NAME	DATE OF BIRTH		RELATIONSHIP TO EMPLOYEE	REQUEST FOR PLAN YEAR	

Dependent Care

Dependent Care Provider	Charge Amount	Payment Due Date	# of Payments Requested

Insurance Premiums

Insurance Carrier	Charge Amount	Payment Due Date	# of Payments Requested

Orthodontic Care

Orthodontia Provider	Charge Amount	Payment Due Date	# of Payments Requested

Participant Agreement:

I verify that the information listed above and the information attached is true and correct. I understand if there are any changes regarding this continual reimbursement that I must notify the Plan Administrator immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible.

_____ Participant's Signature

_____ Date

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PO Box 98
Worland, Wyoming 82401
Phone: 307-426-5500/800-246-4622
Fax: 307-347-6227