Cafeteria Plan Dependent Care Receipt

Notice To Cafeteria Plan Participant

No payment may be made under the plan if the service provider is your dependent for federal income tax purpose, or is your child or stepchild and is under age 19. The Dependent you are claiming must be under age 13 or have qualifying restrictions. **This Form Must Be Submitted Along With A Dependent Care Claim Form**

1 Personal Information

Participant Name

Street Address, City, State, Zip

Dependent Name

Dependent Age

Dependent Name

Dependent Age

Dependent Name

Dependent Age

2 Dependent Care Expenses

Provider Name

Provider Social Security Number or Business ID Number

Provider Street Address, City, State, Zip

Provider Phone Number

$ Amount Received

From: To: Date of Service

Date(s) entered must be date(s) of service rather than the date the fee was paid. Please provide this information in order to avoid delay in the processing and reimbursement of your claim.

3 Provider Signature

I certify that I am providing child care for the participant's dependent named above so the participant may be gainfully employed.

Provider Signature

Date

Please fax, mail, or email your continual reimbursement form and/or receipts to the following:

Mail: National Benefit Services, LLC, P.O. Box 219393, Kansas City, MO 64121-9393

Fax: (844) 438-1496

Email: service@nbsbenefits.com (PDF, TIFF, or JPG files only)