# State of Hawaii Island Flex
# Flexible Spending Accounts (FSA)
# Continual Reimbursement Request

## Dependent Care Expenses

**Please send completed form and required documentation to National Benefit Services.**

## 1 Personal Information

Employee Name (First Name, Last Name)

XXX-XX-
Employee Social Security Number (Required)

Employee Street Address, City, State, Zip Code

Name of Person Receiving Service

State of Hawaii
Employer Name

Employee Email Address

## 2 Dependent Care Instructions

1. Complete the Dependent Care Deduction Worksheet (Section 2a) below and sign Section 4.
2. Determine the Total Annual Expense election for dependent care expenses
   a. Enter Total Annual Expense for dependent care. **Annual Expense may not exceed $5,000 (per household) and $2,500 (if filing individual tax return(s))**
   b. Divide Total Annual Expense by the number of pay periods to calculate your pay period deduction. Each pay period's funds will continue to be dispersed immediately after each payroll is submitted to National Benefit Services by your employer.
3. You are responsible for retaining your receipts for reimbursement. Please submit your receipts yearly in order to continue participating in the continual reimbursement program.

## 2a Dependent Care Deduction Worksheet

$ ______ ÷ ______ = $ ______

Total annual election amount | Number of pay periods | Pay period deduction

## 3 Continual Reimbursement

Expenses for dependent care may not be reimbursed under the plan prior to the time the services are rendered. However, you may be reimbursed under the plan after the services are rendered and prior to the time that the payment is due if those expenses are part of a continual reimbursement request. You may use this form to apply for continual reimbursement. No reimbursement may be paid under the continual reimbursement program for any month in which services are not rendered. It is your responsibility to advise the plan administrator of the cessation or interruption of such services.

## 4 Benefit Election

☐ Yes! Please sign me up for continual reimbursement of my orthodontia expense.

## 5 Employee Signature

I have reviewed the information on this request form and verify that the information listed above and attached is true and correct. I understand that if any changes regarding the continual payment occur, the company must be notified immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible. I also understand that I am responsible for retaining copies of receipts for payment of these expenses, and they must be forwarded to National Benefit Services, LLC each year along with this form to continue participating in the continual reimbursement program.

Employee Signature

Date



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