

# Cafeteria Plan Dependent Care Receipt



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## 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

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### 1 Personal Information

Participant Name

Dependent Name

Street Address, City, State, Zip

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### 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:  
Date of Service

To:

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.

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### 3 Provider Signature

Provider Signature

Date

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**Please fax, mail, or email your claim form and receipts to the following:**

**Mail:** National Benefit Services, LLC, P.O. Box 6980, West Jordan, UT 84084

**Fax:** (844) 438-1496

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