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)

Employee Social Security Number (Required)

Employee Street Address, City, State, Zip Code

Name of Person Receiving Service

Employer Name

Employee Email Address

2 Important Information

Completing this form will allow you to set up automatic reimbursements each month during the current plan year for your dependent care expenses.

- Expenses for dependent care may not be reimbursed under the plan prior to the time the services are rendered.
- No reimbursement may be paid for any month in which services are not rendered. It is your responsibility to notify NBS of the cessation or interruption of such services.
- **Annual expense may not exceed $7,500 per household and $3,750 if filing individual tax returns.**

3 Continual Reimbursement Request Instructions

1. Completely fill out each section of the first page of this form.
2. Sign and date the bottom of this form. We are unable to complete your request if the form is not signed.
3. Submit the completed first page of this form to NBS at the beginning of your plan year.
4. Retain the second page of this form and save your dependent care receipts.
5. At the end of the plan year, submit your saved receipts along with the completed second page of this form to NBS.

- Failure to submit receipts at the end of the plan year will make you ineligible to participate in the continual reimbursement program the following plan year.
- You will need to submit a new continual reimbursement form at the beginning of each plan year if you wish to participate in the continual reimbursement program.

3a Dependent Care Deduction Worksheet

Determine the Total Annual Expense election for dependent care expenses

1. Enter Total Annual Expense for dependent care.
2. 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. Verify the amount being deducted from your paychecks matches the pay period deduction noted below.

$ _____ ÷ _____ = $ _____

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

4 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, National Benefit Services 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 per IRS regulations, and they must be forwarded to National Benefit Services at the end of each plan year along with the second page of this form to be able to sign up for the continual reimbursement program the following year.

Employee 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

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

Continual Reimbursement Substantiation Form

Dependent Care Expenses

Please submit form and receipts for the plan year to National Benefit Services using the contact info below.

1 Personal Information

Employee Name (First Name, Last Name)

Employee Social Security Number (Required)

Employee Street Address, City, State, Zip Code

Name of Person Receiving Service

Employer Name

Employee Email Address

2 Continual Reimbursement Receipt Submission Instructions

1. At the end of the plan year, return this form along with your saved receipts to NBS. Failure to submit receipts at the end of the plan year will make you ineligible to participate in the continual reimbursement program the following plan year.
2. NBS recommends using the attached receipt (page 3) to avoid delays in processing your reimbursement.
3. If you would like to provide an alternative receipt, it must come from an independent third-party (not you, your spouse, or your dependent) and must include the following:
    - Date(s) the services were rendered. (Billing, statement, or payment dates are not eligible dates of service)
    - Description of services (Daycare, preschool, etc.)
    - Amount of services
    - Receipt either needs to be on the provider's letterhead or signed by the provider

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

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

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

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

Dependent Name

Street Address, City, State, Zip

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