Dependent Care Expense Worksheet
Quarterly Continual Reimbursement Form

1 Personal Information

Company Name

Employee Email Address

Employee Name

Employee Social Security Number (Required)

Employee Street Address, City, State, Zip Code

Instructions

Your Dependent Care spending account allows you to save money by paying predictable day care expenses with pre-tax dollars. (Only expenses incurred for Day Care which make it possible for you to work are eligible)

1. Determine your per pay period election for dependent care expenses
   a. Enter the Total Annual Expense for dependent care
      Annual Expense may not exceed $5,000 (married) and $2,500 (if married and filing individual tax returns)
   b. Determine your yearly number of pay periods = weekly/52, bi-weekly/26, semi-monthly/24, monthly/12
   c. Divide the Total Annual Expense by the number of pay periods to calculate your Pay Period Deduction
2. For continual reimbursement please complete the Continual Reimbursement and Service Provider sections
3. Please send the completed form to National Benefit Services, LLC
4. At the end of each quarter resubmit this form with prior quarter receipts to continue reimbursement

2 Pay Period Election

$ _____ ÷ _____ = $ _____

Total Annual Expense | 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 that the dependent care 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 dependent care services are not rendered. It is your responsibility to advise the plan administrator of the cessation or interruption of such services. Your reimbursement will be paid each payroll period. **Receipts for Dependent Care must be received by NBS on a quarterly basis.**

☐ **YES! Please sign me up for continual reimbursement of my Dependent Care Expenses**
Your reimbursement will automatically be sent to you after each payroll period.

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, NBS 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 copies of receipts for payment of these expenses must be forwarded to NBS quarterly or continual reimbursement will cease.**

Employee Signature

Date

5 Service Provider

Provider Name

Business ID Number or SSN

I, the undersigned, hereby certify that the above person will incur/has incurred these expenses.

Provider Signature

Date

6 Quarterly Receipt and Continual Reimbursement Extension

Quarterly Receipts ☐ 1st Quarter ☐ 2nd Quarter ☐ 3rd Quarter ☐ 4th Quarter

Each quarter resubmit this form with the prior quarter's receipts for continued reimbursement

Dependent Name(s)

$ _____ From _____ To _____

Total Receipts | Please continue my continual reimbursement

P.O. Box 6980 West Jordan, UT 84084 • (855) 399-3035 • Fax (844) 438-1496 • my.nbsbenefits.com