

# 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	
\$ Fee For Service	\$ Amount Received	From: To: Date of Service

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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:** Salt Lake Area Fax: (801) 355-0928 • **Toll Free Fax:** (800) 478-1528  
**Email:** [claims@NBSbenefits.com](mailto:claims@NBSbenefits.com) (PDF, TIFF, or JPG files only)