CAFETERIA PLAN
DEPENDENT DAY CARE RECEIPT

PARENT'S NAME:_____

CHILD'S NAME: _____ AGE: ____

DATE OF SERVICE: FROM_____ TO _____

FEE FOR SERVICE: $_____

AMOUNT RECEIVED: $_____

CARE PROVIDED BY:

NAME: _____

ADDRESS:_____

_____

TELEPHONE:_____

SOCIAL SEC# OR BUSINESS ID#_____

PROVIDER SIGNATURE:_____

* 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.

National Benefit Services

THIS FORM MUST BE SUBMITTED ALONG WITH A DEPENDENT CARE CLAIM FORM

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