Continual Reimbursement Request

Orthodontia and Dependent Care Expenses

Please send completed form and required documentation to Kazdon Inc.

Kazdon, Inc.
Payroll • Benefits • FSA

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. Orthodontia Instructions

1. Complete the Orthodontic Expense Worksheet below and sign at the bottom.
2. **Please attach the Orthodontic Treatment and Financial Agreement (Required).** Your orthodontic provider's information and signature is required for reimbursement.
3. You are responsible for retaining your previous year receipts for reimbursement. Please submit your receipts yearly in order to continue participating in the continual reimbursement program.

2a. Orthodontia Instructions

$_____ Total treatment

$_____ Expected insurance coverage

☐ No Insurance Coverage

$_____ Initial payment (if any)

_____ Date paid

$_____ Ortho records/model fee (if separate from treatment fee)

_____ Date paid

$_____ Patients monthly payment (after expected insurance)

_____ Date of first payment

_____ Expected # of months in treatment

$_____ Amount of last payment

☐ Orthodontic treatment and financial agreement attached.

3. Dependent Care Instructions

1. Complete the Dependent Care Deduction Worksheet below and sign at the bottom.
2. Determine the Total Annual Expense election for dependent care expenses.
   a. Enter Total Annual Expense for dependent care. Annual Expense may not exceed $5,000 (per household) and $2,500 (if filing individual tax return(s))
   b. 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. You are responsible for retaining your receipts for reimbursement. Please submit your receipts yearly in order to continue participating in the continual reimbursement program.

3a. Dependent Care Deduction Worksheet

$_____ / _____ = $_____

Total annual election amount / Number of pay periods = Pay period deduction

Continual Reimbursement

Expenses for orthodontia/dependent care may not be reimbursed under the plan prior to the time the 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 services are not rendered. It is your responsibility to advise the plan administrator of the cessation or interruption of such services.

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, the company 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, and they must be forwarded to Kazdon, Inc. each year along with this form to continue participating in the continual reimbursement program.

Employee Signature _____ Date _____