Reset Form

NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge and Expertise • Organizational Excellence

Flexible Spending Account (FSA) Claim Form

Personal Information		
Employee Name		Company Name
Home Address	Change? ☐ Yes ☐ No	Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐
		Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐

For Quick Claim Processing:

- ► Fully Complete & Sign this Claim Form
- ► Attach a copy of supporting receipts, vouchers, bills, etc.
- ► All receipts must detail each of the items summarized below
- ► Please print when using this form
- ► Minimum Total Reimbursement $25

For Account Balance: Go To www.NBSbenefits.com
Or Call
(801) 838-7324 or (888) 353-9125

Please allow 2 business days for claims to be processed

Day Care Expenses

Date of Service (Mo - Day - Yr)	Service Provider Tax ID # or SS#	Child's Name	Age	Amount
☐☐ - ☐☐ - ☐☐				
☐☐ - ☐☐ - ☐☐				
☐☐ - ☐☐ - ☐☐				
Total FSA Day Care Expenses				$ 0 . 0 0

Health Care Expenses
(Please list one expense per line)

Date of Service (Mo - Day - Yr)	Office Visit	RX	Dental	Vision	Over the Counter Drugs	Ortho-Dontia	Other Services: Please Specify	Person Receiving Service	Amount
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
☐☐ - ☐☐ - ☐☐	○	○	○	○	○	○			
								Total FSA Health Expenses	$ 0 . 0 0

Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan, claimed as a Tax Deduction.

Employee Signature	Date
X	

NBS - 402(09/09)

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

Mail: National Benefit Services, LLC P.O. Box 6980, West Jordan, UT 84084
FAX: Salt Lake City Area Fax: (801) 355-0928 Toll Free Fax: (800) 478-1528
Email: claims@NBSbenefits.com (PDF, TIFF or JPEG files only)

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

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.

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