

# Flexible Spending Account (FSA) Claim Form

<b>Personal Information</b>	Employee Name		Company Name							
	Home Address		Social Security Number [ ][ ] - [ ][ ] - [ ][ ][ ][ ]							
	Change? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone Number [ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]							
<b>For Quick Claim Processing:</b> <ul style="list-style-type: none"> <li>▶ Fully Complete &amp; Sign this Claim Form</li> <li>▶ Attach a copy of supporting receipts, vouchers, bills, etc.</li> <li>▶ All receipts must detail each of the items summarized below</li> <li>▶ Please print when using this form</li> <li>▶ Minimum Total Reimbursement \$25</li> </ul>			<b>For Account Balance: Go To</b> <a href="http://www.NBSbenefits.com">www.NBSbenefits.com</a> Or Call (801) 838-7324 or (888) 353-9125 <small>Please allow 2 business days for claims to be processed</small>							
<b>Day Care Expenses</b>	<b>Date of Service</b>	<b>Service Provider</b>		<b>Child's Name</b>	<b>Age</b>	<b>Amount</b>				
	Mo    Day    Yr	Tax ID # or SS#								
	[ ][ ] - [ ][ ][ ] - [ ][ ]					[ ][ ][ ][ ] - [ ][ ][ ]				
	[ ][ ] - [ ][ ][ ] - [ ][ ]					[ ][ ][ ][ ] - [ ][ ][ ]				
	[ ][ ] - [ ][ ][ ] - [ ][ ]					[ ][ ][ ][ ] - [ ][ ][ ]				
<b>Total FSA Day Care Expenses</b>						[ ][ ][ ][ ] - [ ][ ][ ]				
<b>Health Care Expenses</b> <small>(Please list one expense per line)</small>	<b>Date of Service</b>	Office Visit	RX	Dental	Vision	Over the Counter Drugs	Ortho-Dontia	Other Services: Please Specify	Person Receiving Service	<b>Amount</b>
	Mo    Day    Yr									
	[ ][ ] - [ ][ ][ ] - [ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ] - [ ][ ][ ]
	[ ][ ] - [ ][ ][ ] - [ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ] - [ ][ ][ ]
	[ ][ ] - [ ][ ][ ] - [ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ] - [ ][ ][ ]
	[ ][ ] - [ ][ ][ ] - [ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ] - [ ][ ][ ]
	[ ][ ] - [ ][ ][ ] - [ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ] - [ ][ ][ ]
	[ ][ ] - [ ][ ][ ] - [ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ] - [ ][ ][ ]
	[ ][ ] - [ ][ ][ ] - [ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ] - [ ][ ][ ]
	[ ][ ] - [ ][ ][ ] - [ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ] - [ ][ ][ ]
	[ ][ ] - [ ][ ][ ] - [ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ] - [ ][ ][ ]
	<b>Total FSA Health Expenses</b>									[ ][ ][ ][ ] - [ ][ ][ ]
<b>Employee Signature</b>	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 X								Date	

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](mailto: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.



**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# \_\_\_\_\_

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