

# Flexible Spending Account (FSA) Claim Form

<b>Personal Information</b>	Employee Name					Company Name								
	Home Address				Change? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number [ ][ ] - [ ][ ] - [ ][ ][ ][ ]								
						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 in dark blue or black ink 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>Dependant Care Expenses</b>	<b>Date of Service</b>			<b>Service Provider</b>				<b>Dependant's Name</b>		<b>Age</b>	<b>Amount</b>			
	Mo	Day	Yr	Tax ID # or SS#										
	1	[ ][ ]	[ ][ ]	[ ][ ]								[ ][ ][ ][ ]	[ ][ ]	
	2	[ ][ ]	[ ][ ]	[ ][ ]								[ ][ ][ ][ ]	[ ][ ]	
	3	[ ][ ]	[ ][ ]	[ ][ ]								[ ][ ][ ][ ]	[ ][ ]	
<b>Total FSA Day Care Expenses</b>										[ ][ ][ ][ ]	[ ][ ]			
<b>Health Care Expenses</b> (Please list one expense per line)  <b>**Notice**</b>  <small>Effective Jan. 1 2011 all over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulation</small>	<b>Date of Service</b>			Office Visit	RX	Dental	Vision	Non-Drug OTC	Ortho-dontia	Other Services: Please Specify	Person Receiving Service	<b>Amount</b>		
	Mo	Day	Yr											
	1	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]
	2	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]
	3	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]
	4	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]
	5	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]
	6	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]
	7	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]
	8	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]
	9	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]
10	[ ][ ]	[ ][ ]	[ ][ ]	○	○	○	○	○	○			[ ][ ][ ][ ]	[ ][ ]	
<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, or claimed as a tax deduction.													
	Employee Signature X										Date			

NBS - 402(10/10)

**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)