125 Cafeteria Plan Enrollment Form

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

(Please complete this form and return it to your Human Resource Department)

Personal Information

Company Name

First Name | Last Name | Social Security Number - (Required) - -

Street Address | Date Of Birth - (Required) - -

City | State | Zip Code | Date Of Hire - (Required) - -

Email Address (Required for ACH claim payment notification) | Phone Number - -

Benefit Election

If you are part of a company health insurance plan your insurance premiums will automatically be paid pre-tax by payroll deduction. You may also choose any of the following benefits to add to your pre-tax deduction:

☐ **Health Care Expenses:** $. PER YEAR
Please refer to the SPD for the maximum annual allowable election

☐ **Day Care Expenses:** $. PER YEAR
Maximum annual allowable election is $5,000 OR $2,500 if married and filing taxes separately

☐ Initial Request
☐ New Year Request
☐ Waive Participation

Debit Card

Would you like a Debit Card? **(For health Expenses only)** ☐ Yes ☐ No There is a $18 per year fee for the use of the Debit Card.

You will receive 2 debit cards in the participant's name, one for you and one for your spouse or dependent.

Employee Signature

I hereby authorize the appropriate payroll reductions as my contribution(s) to the Cafeteria Plan until changed by me in writing. I recognize that such payroll reductions shall be adjusted automatically in the event of a change in the insurance premiums of the benefits I have selected. I will only use the Flexible Spending Account (including the use of a Debit Card) for eligible expenses under the plan, and understand I will be responsible to pay for any transactions not allowed by the plan. In addition, I authorize the release of medical and account information to my spouse (if applicable).

Employee Signature
X
Date

Direct Deposit Request

Your Financial Institution | ☐ Checking Account ☐ Savings Account

Financial Institution Address | Routing Number | Account Number

IMPORTANT! Please attach a voided check with this form (not a deposit slip). Only for a savings account is a deposit slip acceptable.

I (We) authorize National Benefit Services, LLC to initiate credit entries and, if necessary, debit and adjustment entries for any credit entries and adjustments made in error to my (our) account indicated above and the financial institution named above.

Employee Signature
X
Date

NBS - 418(09/09)

National Benefit Services, LLC
P.O. Box 6980, West Jordan, UT 84084 PH (888)353-9125 Toll Free Fax (800) 478-1528

Please return to your Human Resource department

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Health Care Expense Worksheet

(This worksheet is for estimating annual health care expenses only. To enroll, please complete an Enrollment Form)

Instructions	1. Enter your annual cost for each health care option you use 2. Add up the Total Annual Health Care Expense 3. Determine your yearly Number of Pay Periods = Weekly/52, Bi-Weekly/26, Semi-Monthly/24, Monthly/12 4. Divide the Total Annual Expense by the number of pay periods to calculate the amount needed to be withheld every pay period		
Medical Care	Insurance Deductibles	$	____________
	Co-pays	$	____________
	Routine Exams	$	____________
	Prescriptions	$	____________
	Lab Expenses	$	____________
	Medical Equipment	$	____________
	Chiropractor Visits	$	____________
	Physical Therapy	$	____________
	Other	$	____________
	Total Annual Medical Care Expense	$	____________
Vision Care	Eye Exams	$	____________
	Glasses	$	
	Prescription Sun Glasses	$	____________
	Contacts	$	____________
	Contact Lens Solutions	$	____________
	Insurance Deductibles/Co-pays	$	____________
	Limited FSA		
	Total Annual Vision Care Expense	$	____________
Dental Care	Cleanings	$	____________
	X-rays	$	
	Crowns	$	____________
	Other	$	____________
	Total Annual Dental Care Expense	$	____________
Orthodontics	Orthodontia	$	____________
	Retainers	$	____________
	Total Annual Orthodontia Care Expense	$	____________

Totals	Total Annual Health Care Expense		Number of Pay Periods		Total Pay Period Deduction
	$	÷		=	$

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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 in dark blue or blak ink 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
1	- -				.
2	- -				.
3	- -				.
	Total FSA Day Care Expenses				.

Health Care Expenses (Please list one expense per line)

****Notice****

Effective Jan. 1 2011 all over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulation

	Date of Service (Mo - Day - Yr)	Office Visit	RX	Dental	Vision	Non-Drug OTC	Ortho-dontia	Other Services: Please Specify	Person Receiving Service	Amount
1	- -	O	O	O	O	O	O			.
2	- -	O	O	O	O	O	O			.
3	- -	O	O	O	O	O	O			.
4	- -	O	O	O	O	O	O			.
5	- -	O	O	O	O	O	O			.
6	- -	O	O	O	O	O	O			.
7	- -	O	O	O	O	O	O			.
8	- -	O	O	O	O	O	O			.
9	- -	O	O	O	O	O	O			.
10	- -	O	O	O	O	O	O			.
									Total FSA Health Expenses	.

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, 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 (PDF, TIFF or JPEG files only)

Dependent Care Expense Worksheet
Continual Reimbursement Form

Personal Information

Employee Name	Company Name
Address	Social Security Number
	Email Address

Instructions

Your Dependent Care spending account allows you to save money by paying predictable day care expenses with pre-tax dollars. (Only expenses incurred for Day Care which make it possible for you to work are eligible)

1. Determine your per pay period election for dependent care expenses
   a. Enter the Total Annual Expense for dependent care
   b. Determine your yearly number of pay periods = weekly/52, bi-weekly/26, semi-monthly/24, monthly/12
   c. Divide the Total Annual Amount by the number of Pay Periods to calculate your Pay Period Deduction
   [Annual Expenses may not exceed $5,000 (Married) and $2,500 (If married and filing individual tax returns)]
2. For continual reimbursement please complete the Continual Reimbursement and Service Provider sections
3. Please send the completed form to National Benefit Services, LLC
4. **At the end of each quarter resubmit this form with prior quarter receipts to continue reimbursement**

Pay Period Election

Total Annual Expense	Number of Pay Periods	Pay Period Deduction
$___________________________ ÷	___________________________=	$____________________

Continual Reimbursement

Expenses for dependent care may not be reimbursed under the plan prior to the time that the dependent care 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 dependent care services are not rendered. It is your responsibility to advise the plan administrator of the cessation or interruption of such services. Your reimbursement will be paid each payroll period. **Receipts for Dependent Care must be received by NBS on a quarterly basis.**

Limited FSA

☐ **YES! Please sign me up for continual reimbursement of my Day Care expense.**

Your reimbursement will automatically be sent to you after each payroll period.

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, NBS 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 copies of receipts for payment of these expenses must be forwarded to NBS quarterly or continual reimbursement will cease.**

Employee Signature	Date
Address	

I, the undersigned, hereby certify that the above person will/has incurred these expenses.

Business ID # or Social Security #	Provider Signature X____

Quarterly Receipt and Continual Reimbursement Extension

(Each quarter resubmit this form with the prior quarter's receipts for continued reimbursement)

1st Quarter Receipts
Dependent Name: _______________________________
Total Receipts: $_______________________________
Please continue my continual reimbursement for the next:
☐ 3 Months ☐ Other ________________________

2nd Quarter Receipts
Dependent Name: _______________________________
Total Receipts: $_______________________________
Please continue my continual reimbursement for the next:
☐ 3 Months ☐ Other ________________________

3rd Quarter Receipts
Dependent Name: _______________________________
Total Receipts: $_______________________________
Please continue my continual reimbursement for the next:
☐ 3 Months ☐ Other ________________________

4th Quarter Receipts
Dependent Name: _______________________________
Total Receipts: $_______________________________
Please complete a new form for the new year

National Benefit Services, LLC
P.O. Box 6980, West Jordan, UT 84084 PH (801)838-7324 Toll Free (888) 353-9125