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

Flexible Spending Account (FSA)
Health Care and Dependent Care Claim Form

Personal Information

Employee Name	Company Name
Home Address	Address Change ☐ Yes ☑ No
	Social Security Number ___ – __ – ____

For Quick Claim Processing:

- ► 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:
www.NBSbenefits.com

Health Care Expenses
(Please list one expense per line)

Date of Service Mo - Day - Yr	Office Visit	RX	Dental	Vision	over the counter drugs	Other Services: Please Specify	Person Receiving Service	Amount
__ - __ - __	○	○	○	○	○			.
__ - __ - __	○	○	○	○	○			.
__ - __ - __	○	○	○	○	○			.
__ - __ - __	○	○	○	○	○			.
__ - __ - __	○	○	○	○	○			.
__ - __ - __	○	○	○	○	○			.
__ - __ - __	○	○	○	○	○			.
__ - __ - __	○	○	○	○	○			.
Total Health Care Expense								.

Dependent Expenses

Date of Service Mo - Day - Yr	Service Provider Tax ID # or SS#	Child's Name	Age	Amount
__ - __ - __				.
__ - __ - __				.
__ - __ - __				.
Total Day Care Expense				.

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 or Tax Credit.

Employee Signature	Date
X	

NBS - 402(9/06)

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

Mail: National Benefit Services, LLC 8805 S. Sandy Parkway, Sandy, UT 84070
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)