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:

- ► 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 48 hours for claims to be processed

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 Expenses	.

Dependent Expenses

Date of Service (Mo - Day - Yr)	Service Provider Tax ID # or SS#	Child's Name	Age	Amount
- -				.
- -				.
- -				.
		Total Day Care 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, claimed as a Tax Deduction or Tax Credit.

Employee Signature	Date
X	

NBS - 402(07/08)

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

Mail: National Benefit Services, LLC P.O. Box 698, 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)