

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

<b>Personal Information</b>	Employee Name	Company Name
	Home Address	Address Change <input type="checkbox"/> Yes <input type="checkbox"/> No
	Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	

<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:</b> Go To <a href="http://www.NBSbenefits.com">www.NBSbenefits.com</a>  Or Call (801) 838-7324 or (888) 353-9125  <small>Please allow 48 hours for claims to be processed</small>
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<b>Health Care Expenses</b> <small>(Please list one expense per line)</small>	Date of Service			Office Visit	RX	Dental	Vision	Over the Counter Drugs	Other Services: Please Specify	Person Receiving Service	Amount
	Mo	Day	Yr								
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="text"/>
<b>Total Health Care Expenses</b>											<input type="text"/>

<b>Dependent Expenses</b>	Date of Service			Service Provider Tax ID # or SS#	Child's Name	Age	Amount
	Mo	Day	Yr				
	<input type="text"/>	<input type="text"/>	<input type="text"/>				<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>				<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>				<input type="text"/>
<b>Total Day Care Expenses</b>							<input type="text"/>

<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 or Tax Credit.	
	Employee Signature X	Date

**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](mailto:claims@NBSbenefits.com) (PDF, TIFF or JPEG files only)