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

125 Cafeteria Plan
Enrollment Packet

The following information is found in this enrollment packet:

- **Enrollment Form:** To sign up, please complete this form.
- **Health Care Expense Worksheet:** A worksheet that can be used in estimating annual health care expenses.
- **Participant Account Web Access:** Explanation of the online participant account system. Provides logon information for first time users, and an example of the information available online.
- **Claim Form:** This form can be used to submit claims for reimbursement.
- **Dependent Care Expense Worksheet/Continual Reimbursement Form:** This form will help you determine the amount of Dependent Care money you are able to deduct, and provides information on the Continual Reimbursement Program.

The following information can be found on our website under Forms at:
www.participant.nbsbenefits.com

- **Orthodontic Expense Worksheet/Continual Reimbursement Form:** This form will help you determine Orthodontic expenses and service schedules that qualify for Cafeteria Plan spending, and provides information on Continual Reimbursement.
- **Information on Flexible Spending Accounts:** IRS Publications and summary plan information
- **Change of Status Form:** For employer notification of a change in status and benefit.
- **Claim Form:** For submitting eligible medical and dependent care claims for reimbursement.
- **Direct Deposit Request:** Have your reimbursements sent directly to your checking account.

P.O. Box 6980 West Jordan, UT 84084 ● (855) 399-3035 ● Fax (844) 438-1496 ● www.participant.nbsbenefits.com

125 Cafeteria Plan Enrollment Form

Please complete this form and return it to your Human Resources Department

1 Personal Information

Employee Name (First Name, Last Name) | Company Name

Street Address | City | State | Zip Code | Social Security Number

Employee Phone Number | Date of Birth | Date of Hire (Required) | Email Address (Required to receive e-mail communications)

2 Benefit Election

☐ Initial Request ☐ New Year Request ☐ Waive Participation

If you are part of a company health insurance plan your 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:

Number of pay periods per year: **(Required)** ☐ Bi-weekly (26) ☐ Weekly (52) ☐ Semi-monthly (24) ☐ Monthly (12)

☐ Health Care Expenses:
Must not exceed $2,500/year as per IRS regulations

Enrollment Effective Date (Required)

$ ________ **Per pay period election (Required)**

$ ________ Annual Election

☐ Dependent Care Expenses:
Maximum annual allowable election is $5,000 per year OR $2,500 per year if married and filing taxes separately

Enrollment Effective Date (Required)

$ ________ **Per pay period election (Required)**

$ ________ Annual Election

3 Direct Deposit Request

☐ Checking Account
☐ Savings Account

Your Financial Institution

Financial Institution Address

Account Number | Routing Number

IMPORTANT! Please attach a voided check with this form (not a deposit slip). Only for a savings account is a deposit slip acceptable. If you have Direct Deposit information on file it carries forward unless corrected or rescinded in writing by you.

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 | Date

4 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. I will only use the Flexible Spending Account 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 | Date

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Health Care Expense Worksheet

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Instructions

This worksheet is for estimating annual health care expenses only.

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

1 Medical Care

Insurance Deductibles $ ____________________

Co-pays $ ____________________

Routine Exams $ ____________________

Prescriptions $ ____________________

Lab Expenses $ ____________________

Medical Equipment $ ____________________

Chiropractor Visits $ ____________________

Physical Therapy $ ____________________

Other $ ____________________

Total Annual Medical Care Expenses $ ____________________

2 Vision Care

Eye Exam $ ____________________

Glasses $ ____________________

Prescription Sun Glasses $ ____________________

Contacts $ ____________________

Contact Lens Solutions $ ____________________

Insurance Deductibles/Co-pays $ ____________________

Total Annual Vision Care Expenses $ ____________________

3 Dental Care

Cleanings $ ____________________

X-Rays $ ____________________

Crowns $ ____________________

Other $ ____________________

Total Annual Dental Care Expenses $ ____________________

4 Orthodontia Care

Orthodontia $ ____________________

Retainers $ ____________________

Total Annual Orthodontia Care Expenses $ ____________________

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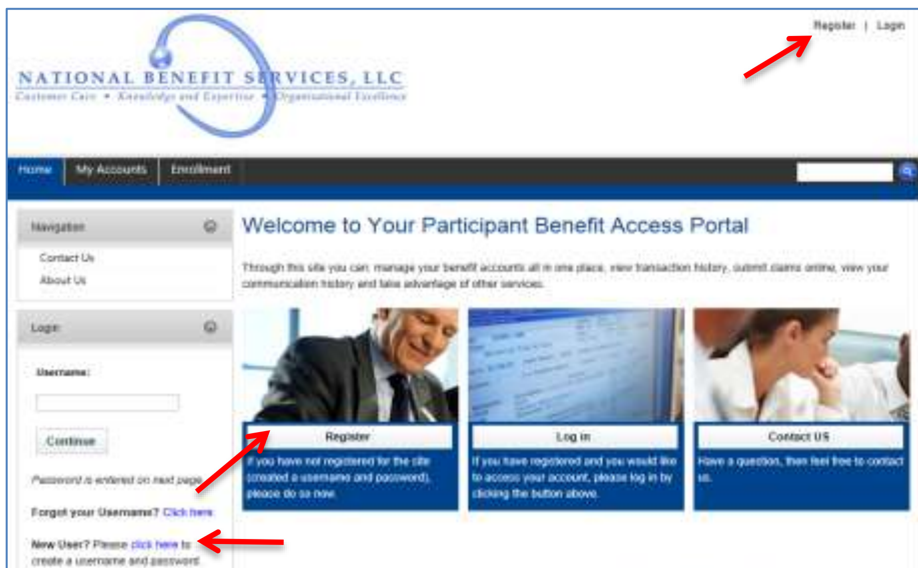
The NBS Web Portal- First Time Login

▶ Features of the Portal:

- **Interact with balances, summaries, and highlights** of all your benefit accounts
- **Get detailed transaction history** showing all deposits and payments of each account
- **Track all of your medical expenses** using a claim manager and take advantage of our easy-to-use claim entry and reimbursement request process
- **Order new debit cards** or report your debit card as lost/stolen
- **Stay up-to-date with announcements and communication** from both NBS and your plan sponsor
- **Take advantage of endless informational resources** such as calculators, videos, and FAQ's

▶ Login Step #1 participant.nbsbenefits.com

1. **Using your internet browser, navigate to: http://participant.nbsbenefits.com.**
2. **Click "Register" in one of the three locations on the home page.**



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The NBS Web Portal- First Time Login continued:

▶ Login Step #2

Complete the required fields as a first time user:

- User Name & Password
- Personal Information- Name & Email Address
- Employee ID is your SSN
- Employer ID or NBS Debit Card Number
    - Employer ID is a 9 digit code given to you in your welcome email from NBS, or may be obtained through your employer or contacting NBS at 855-399-3035.
- Accept Terms & Conditions

After completing the required fields click "Register"

User Name:
Password:
Confirm Password: You must provide a password confirmation
First Name:
Last Name:
Email Address:
Employee ID
Registration ID Employer ID
Accept Terms of Use View Terms of Use
Register Cancel

▶ Contact NBS should you have any questions

National Benefit Services, LLC
Phone: 855-399-3035
Email: service@nbsbenefits.com

Flexible Spending Account (FSA) Claim Form

Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must detail each of the items summarized below
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Minimum Total Reimbursement = $25
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to www.participant.nbsbenefits.com
or call (855) 399-3035

Notice
All over-the-counter (OTC) medication claims must be accompanied by a prescription to be eligible under new federal regulations

1 Personal Information

Employee Name ______________________ Company Name ______________________

Street Address, City, State, Zip ______________________ Address Change? ☐ No ☐ Yes

Phone Number ______________________ Social Security Number ______________________

2 Dependent Care Expenses

	Date of Service MM	DD	YY	Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
1							
2							
3							

Total Dependent Care Expenses ______________

3 Health Care Expenses

	Date of Service MM	DD	YY	Office Visit	Rx	Dental	Vision	Non-Drug OTC	Ortho dontia	Other Services: Please Specify	Person Receiving Service	Amount
1				☐	☐	☐	☐	☐	☐			
2				☐	☐	☐	☐	☐	☐			
3				☐	☐	☐	☐	☐	☐			
4				☐	☐	☐	☐	☐	☐			
5				☐	☐	☐	☐	☐	☐			
6				☐	☐	☐	☐	☐	☐			
7				☐	☐	☐	☐	☐	☐			
8				☐	☐	☐	☐	☐	☐			
9				☐	☐	☐	☐	☐	☐			

Total Health Care Expenses ______________

4 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 ______________________ Date ______________

Please fax, mail, or email your claim form and receipts to the following:
Mail: National Benefit Services, LLC, P.O. Box 6980, West Jordan, UT 84084
Fax: (844) 438-1496
Email: service@nbsbenefits.com (PDF, TIFF, or JPG files only)

Dependent Care Expense Worksheet
Quarterly Continual Reimbursement Form

1 Personal Information

Company Name

Employee Email Address

Employee Name

Employee Social Security Number (Required)

Employee Street Address, City, State, Zip Code

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
      Annual Expense may not exceed $5,000 (married) and $2,500 (if married and filing individual tax returns)
   b. Determine your yearly number of pay periods = weekly/52, bi-weekly/26, semi-monthly/24, monthly/12
   c. Divide the Total Annual Expense by the number of pay periods to calculate your Pay Period Deduction
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

2 Pay Period Election

$ ________ ÷ ________ = $ ________

Total Annual Expense | Number of Pay Periods | Pay Period Deduction

3 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.**

☐ **YES! Please sign me up for continual reimbursement of my Dependent Care Expenses**

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

4 Employee Signature

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

5 Service Provider

Provider Name

Business ID Number or SSN

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

Provider Signature

Date

6 Quarterly Receipt and Continual Reimbursement Extension

Quarterly Receipts ☐ 1st Quarter ☐ 2nd Quarter ☐ 3rd Quarter ☐ 4th Quarter

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

Dependent Name(s)

$ ________ From ________ To ________

Total Receipts | Please continue my continual reimbursement

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