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.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.

8523 S Redwood Rd, West Jordan, UT 84088 ● (801) 532-4000, (800) 274-0503 ● Fax (801) 355-0928 ● www.NBSbenefits.com

125 Cafeteria Plan Enrollment Form

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

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

1 Personal Information

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

Street Address, City, State, Zip _____ Social Security Number (Required) _____

Employee Phone Number _____ Date of Birth (Required) _____ Date of Hire (Required) _____ Email Address (Required for ACH claim payment notification)) _____

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: _____

☐ Health Care Expenses: $ _____ Annual Election and
Must not exceed $2,500/year as per IRS regulations
$ _____ Per Pay Period Election

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

3 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 _____

4 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 _____

8523 S Redwood Rd, West Jordan, UT 84088 ● (801) 532-4000, (800) 274-0503 ● Fax (801) 355-0928 ● www.NBSbenefits.com

Health Care Expense Worksheet

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

Instructions

This worksheet is for estimating annual health care expenses only. To enroll, please complete an Enrollment Form. Note: Annual election amount must not exceed $2,500/year as per IRS regulations.

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	$ _____

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 _____

8523 S Redwood Rd, West Jordan, UT 84088 ● (801) 532-4000, (800) 274-0503 ● Fax (801) 355-0928 ● www.NBSbenefits.com

Participant Account Web Access

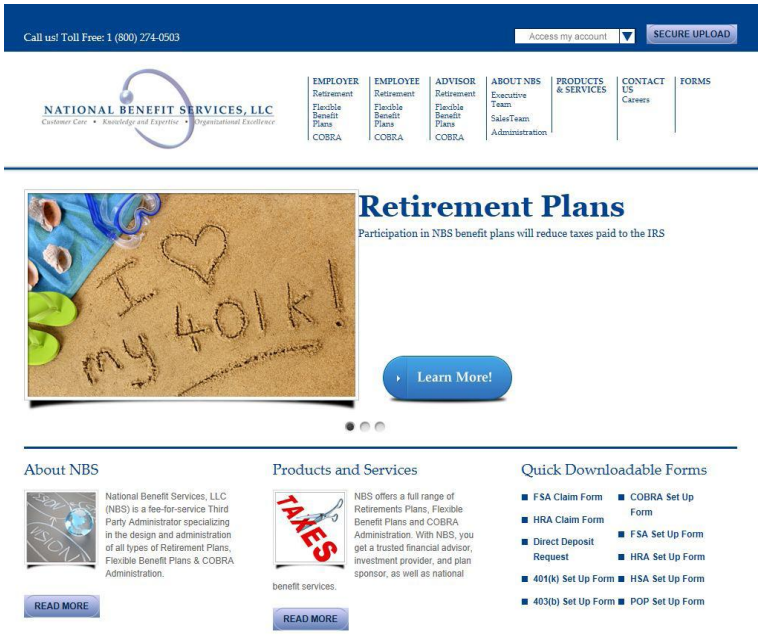
1 Information

National Benefit Services, LLC provides a website for participants to access account information. This site offers:

- Access to detailed Claim History
- Heath Reimbursement and Dependant Care account information
- Access to downloadable forms such as Claim and Change of Status Forms
- A list of what is eligible for reimbursement
- Access 24 hours a day, 7 days a week

2 Instructions

1. **Using your internet browser, navigate to: www.nbsbenefits.com.**
2. **Click on "Access my Account" link on the upper right hand side- then click on "Flexible Benefit Plans"**



3. **Enter your Login Information or follow the Instructions for a first time user**

8523 S Redwood Rd, West Jordan, UT 84088 ● (801) 532-4000, (800) 274-0503 ● Fax (801) 355-0928 ● www.NBSbenefits.com

Flexible Spending Account (FSA) Claim Form

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

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.NBSbenefits.com
or call (801) 838-7324 or (888) 353-9125

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 _____ ☐No ☐Yes Address Change?

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: Salt Lake Area Fax: (801) 355-0928 • **Toll Free Fax:** (800) 478-1528
Email: claims@NBSbenefits.com (PDF, TIFF, or JPG files only)

Dependent Care Expense Worksheet
Quarterly Continual Reimbursement Form

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

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

8523 S Redwood Rd, West Jordan, UT 84088 ● (801) 532-4000, (800) 274-0503 ● Fax (801) 355-0928 ● www.NBSbenefits.com