



Cafeteria Plan Claim Form

Personal Information	Employee Name <p style="text-align:center">John Smith</p>	Company Name <p style="text-align:center">XYZ Company</p>										
	Home Address <p style="text-align:center">123 East Elm Street Salt Lake City, UT 84115</p>	Address Change <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
		Social Security Number <table style="width:100%; text-align:center; border-collapse: collapse;"> <tr> <td style="border:1px solid black; width:20px;">1</td> <td style="border:1px solid black; width:20px;">2</td> <td style="border:1px solid black; width:20px;">3</td> <td style="border:1px solid black; width:20px;">-</td> <td style="border:1px solid black; width:20px;">4</td> <td style="border:1px solid black; width:20px;">5</td> <td style="border:1px solid black; width:20px;">-</td> <td style="border:1px solid black; width:20px;">6</td> <td style="border:1px solid black; width:20px;">7</td> <td style="border:1px solid black; width:20px;">8</td> <td style="border:1px solid black; width:20px;">9</td> </tr> </table>	1	2	3	-	4	5	-	6	7	8
1	2	3	-	4	5	-	6	7	8	9		
For Quick Claim Processing: <ul style="list-style-type: none"> ▶ 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 Reimbursement = \$25 		For Account Balance: www.nbsionline.com										

Date of Service	Office Visit	RX	Dental	Vision	over the counter drugs	Other Services: Please Specify	Person Receiving Service	Amount			
								Mo	Day	Yr	
1 0 - 1 5 - 0 6	X	O	O	O	O			2	0	0	0
0 9 - 0 2 - 0 6	O	O	X	O	O			1	5	0	0
0 5 - 2 1 - 0 6	O	O	O	X	O			1	8	7	2
- - -	O	O	O	O	O						
- - -	O	O	O	O	O						
- - -	O	O	O	O	O						
- - -	O	O	O	O	O						
Total Health Care Expense								3	5	7	2

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

Employee Signature	I, the undersigned, attest that to the best of my knowledge these statements are complete and true. 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. I authorize the release of any medical information to my spouse.	
Employee Signature	<i>John Smith</i>	Date 11/21/2006

NBS - 402(01/04)

Please fax or mail your claim form and receipts to the following:
 National Benefit Service, LLC 8805 S. Sandy Parkway, Sandy, UT 84070
Toll Free Fax: (800) 478-1528 Salt Lake City Area Fax: (801) 355-0928