

# Limited Flexible Spending Account Claim Form For Dental, Vision and Preventative Care

<b>Personal Information</b>	Employee Name	Company Name									
	Home Address	Address Change <input type="checkbox"/> Yes <input type="checkbox"/> No									
	Social Security Number <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> </tr> </table>										
<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: Go To</b> <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>									

<b>Health Care Expenses</b> <small>(Please list one expense per line)</small>	Date of Service			Dental	Vision	Preventative Care	Please Specify Type Of Preventative Care	Person Receiving Service	Amount
	Mo	Day	Yr						
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/>
	<b>Total Health Care Expenses</b>								<input type="text"/>

<b>Dependent Expenses</b>	Date of Service			Service Provider	Child's Name	Age	Amount
	Mo	Day	Yr	Tax ID # or SS#			
	<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 6980, 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)