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.
- **Debit Card (National Benefit Services Card):** Information on the NBS debit card that allows you to charge your qualified medical expenses and when it can be used.
- **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.
- **HIPAA Privacy Notice:** **This notice describes the medical information practices of National Benefit** Services, LLC in the administration of medical claims.

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 ● (800) 274-0503 ● Fax (801) 355-0928 ● www.NBSbenefits.com

125 Cafeteria Plan Enrollment Form

NATIONAL BENEFIT SERVICES, LLC
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(Please complete this form and return it to your Human Resource Department)

Personal Information

Company Name	Employee Phone Number
Employee Name	Social Security Number (Required)
Street Address, City, State Zip	Date of Birth (Required)
Email Address (Required for ACH claim payment notification)	Date of Hire (Required)

Benefit Election

☐ Initial Request ☐ New Year Request ☐ Waive Participation

If you are part of a company health insurance plan your insurance 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:
Please refer to the SPD for the maximum annual allowable election
$_____._____ Annual Election and
$_____._____ Per Pay Period Election

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

Debit Card (Health Care Expenses only)

Would you like a Debit Card? ☐ Yes ☐ No

You will receive 2 debit cards, one for you and one for your spouse or dependent.

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 of the benefits I have selected. I will only use the Flexible Spending Account (including the use of a Debit Card) 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

Direct Deposit Request

Your Financial Institution		
Financial Institution Address		
☐ Checking Account ☐ Savings Account	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

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

Welfare-509 (11/2011)

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Health Care Expense Worksheet

Instructions

This worksheet is for estimating annual health care expenses only. To enroll, please complete an Enrollment Form

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

Medical Care

Insurance Deductibles	$ _____
Co-pays	$ _____
Routine Exams	$ _____
Prescriptions	$ _____
Lab Expenses	$ _____
Medical Equipment	$ _____
Chiropractor Visits	$ _____
Physical Therapy	$ _____
Other	$ _____
Total Annual Medical Care Expense	$ _____

Vision Care

Eye Exam	$ _____
Glasses	$ _____
Prescription Sun Glasses	$ _____
Contacts	$ _____
Contact Lens Solutions	$ _____
Insurance Deductibles/Co-pays	$ _____
Total Annual Vision Care Expense	$ _____

Dental Care

Cleanings	$ _____
X-Rays	$ _____
Crowns	$ _____
Other	$ _____
Total Annual Dental Care Expense	$ _____

Orthodontia Care

Orthodontia	$ _____
Retainers	$ _____
Total Annual Orthodontia Care	$ _____

Totals

Total Annual Health Care Expenses		Number of Pay Periods		Total Pay Period Deduction
$	÷		=	$

Welfare-514 (06/2011)

NBS Prepaid Visa Card

The Smart Way To Pay For The Things You Need

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The NBS® Prepaid Visa® Card	As part of your cafeteria program, you can receive your own NBS card that makes using your flex dollars easier than ever. As long as the merchant or service provider accepts Visa credit cards, there's no need to pay cash up front and then wait for reimbursement.
Here's How It Works	1. Enroll in the cafeteria benefit program and select an annual contribution amount. 2. Pre-tax funds are loaded into your account via payroll deduction. 3. You receive your NBS card in the mail, and can use it immediately for qualified expenses. Funds are deducted directly from your flex account. Purchases that exceed the available funds are declined, and you'll have to use another form of payment and submit a claim for reimbursement. 4. The NBS card is a debit card but similar to a credit card in that you always select "Credit" and sign for purchases. Your card does not require a PIN and you cannot withdraw cash. If the merchant or service provider does not accept Visa credit cards, you'll need to use another form of payment and submit a claim for reimbursement. 5. Use your card at doctors' offices, hospitals, dentist offices, optical centers, pharmacies and other health providers. Purchases made at these stores will automatically be adjudicated. Just swipe your card to pay for eligible items and then provide another tender for non-eligible purchases.
Approved Stores	Please see http://sig-is.org/card-holders/store-locator for a complete list of stores that accept the card.
Please Note Welfare-519 (10/2011)	Debit cards will be ordered after all plan setup and enrollment materials are received by NBS. You are required to keep all receipts for purchases. You may be required to submit receipts for adjudication on transactions made on the card. Any use of the card for ineligible purchases will require you to refund money back to the plan.

Sign up for a flexible spending program today, and keep those hard earned dollars in your wallet. Contact your Human Resource Department for more information.

8523 S Redwood Rd, West Jordan, UT 84088 ● (888) 353-9125 ● Fax (800) 478-1528 ● www.NBSbenefits.com

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Participant Account Web Access

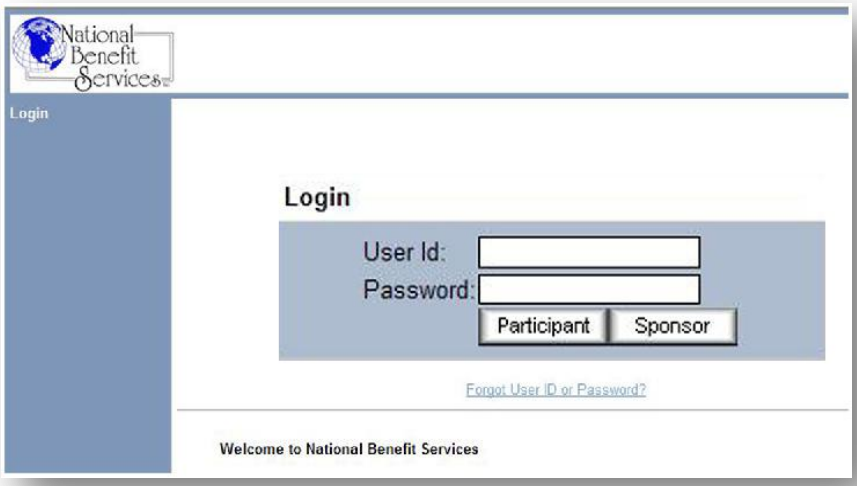
Information

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

Instructions

To log on to your personal web account go to:
www.NBSbenefits.com



First Time Users:
USER ID: SS# (no dashes)
PASSWORD: Last four digits of your SS #

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Flexible Spending Account (FSA) Claim Form

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Personal Information

Employee Name				Company Name
Street Address	City	State	Zip	Address Change? ☐No ☐Yes
Phone Number	Social Security Number			For Account Balance: Go to www.NBSbenefits.com or call (801) 838-7324 or (888) 353-9125

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 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

Dependent Care Expenses

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

Health Care Expenses

(Please list one expense per line)

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

	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 FSA Health Expenses		

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

Welfare-506 (07/2011)

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 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
Continual Reimbursement Form

NATIONAL BENEFIT SERVICES, LLC
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Personal Information

Company Name	Employee Email Address
Employee Name	Employee Social Security Number
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**

Pay Period Election

Total Annual Expense		Number of Pay Periods		Pay Period Deduction
$	÷		=	$

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.

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

Service Provider

Provider Name	Business ID Number or Social Security Number

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

Provider Signature	Date

Quarterly Receipt and Continual Reimbursement Extension

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

1st Quarter Receipts	2nd Quarter Receipts
Dependent Name	Dependent Name
Total Receipts $	Total Receipts $
Please continue my continual reimbursement for the next ☐3 Months ☐Other_____	Please continue my continual reimbursement for the next ☐3 Months ☐Other_____
3rd Quarter Receipts	**4th Quarter Receipts**
Dependent Name	Dependent Name
Total Receipts $	Total Receipts $
Please continue my continual reimbursement for the next ☐3 Months ☐Other_____	Please continue my continual reimbursement for the next ☐3 Months ☐Other_____

National Benefit Services, LLC
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)

HIPAA Privacy Notice
Effective Date: 1 April 2009

This Notice Describes How Medical Information About You as a Participant in the Cafeteria Plan (the "Plan") May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.

This notice describes the medical information practices of National Benefit Services, LLC in the administration of the Cafeteria or HRA Plan medical claims.

Our Pledge Regarding Medical Information
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for plan administration purposes.

This notice applies to all of the medical records provided to you by us that we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Your Rights Regarding Medical Information About You
You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy
You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request in writing that the denial be reviewed.

Right to an Accounting of Disclosures
You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations. To request this list or accounting of disclosures, you must submit your request in writing. Your request must state a time period which may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. HIPAA privacy laws do not require compliance with your request.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make a written request. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a paper copy of this notice upon written request. You may obtain a copy of this notice at our website: www.NBSbenefits.com

Changes to This Notice
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the NBS website. The notice will contain on the first page the effective date.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with National Benefit Services, LLC or with the Secretary of the Office for Civil Rights of the U.S. Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the services that we provided to you.

Written Requests and Complaints
Send all written requests and complaints to:
National Benefit Services, LLC
Attn: Privacy Officer
PO Box 6980
West Jordan, Utah 84084