State of Hawaii Island Flex
Flexible Spending Accounts (FSA)
NBS Orthodontic Contract

1 Personal Information

Plan Participant Name (First Name, Last Name)

Name of Person Receiving Service

Participant Employer

Participant Social Security Number (Required)

Instructions

1. Complete the Orthodontic Expense and Service Schedule below
2. Your orthodontic provider's information and signature is required for reimbursement
3. This form must be submitted along with a Claim Form or Continual Reimbursement Form unless you are using your NBS Card for payment on services
4. Send all information to National Benefit Services, LLC

2 Orthodontic Expense and Service Schedule

$ Total Treatment Fee

$ Expected Insurance Coverage

☐ No Coverage If No Insurance Coverage

$ Initial payment (If Any)

Date Paid

$ Ortho Records/Model Fee (If separate from treatment fee)

Date Paid

$ Patients Monthly Payment (after expected insurance)

Beginning Date of Monthly Payments

Expected # of Months in Treatment

	First Year: 20_____	Second Year: 20_____	Third Year: 20_____
January	$	$	$
February	$	$	$
March	$	$	$
April	$	$	$
May	$	$	$
June	$	$	$
July	$	$	$
August	$	$	$
September	$	$	$
October	$	$	$
November	$	$	$
December	$	$	$

3 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 Orthodontic Contract occur, the company must be notified immediately. Failure to do so could result in additional taxes being applicable for which I would be responsible.

Expenses for orthodontia may not be reimbursed under the plan prior to the time the orthodontia 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. It is your responsibility to advise the plan administrator of the cessation or interruption of such services.

Employee Signature

Date

4 Service Provider

Orthodontist Name

Orthodontist Phone Number

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

Orthodontist Signature

Business ID#

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)

State of Hawaii Island Flex
Flexible Spending Accounts (FSA)
Continual Reimbursement Request

Orthodontia Care Expenses

Please send completed form and required documentation to National Benefit Services.

1 Personal Information

Employee Name (First Name, Last Name)

Employee Social Security Number (Required)

Employee Street Address, City, State, Zip Code

Name of Person Receiving Service

State of Hawaii

Employer Name

Employee Email Address

2 Orthodontia Instructions

1. Complete the Orthodontic Expense Worksheet (Section 2a) below and sign Section 5.
2. **Please attach the Orthodontic Treatment and Financial Agreement (Required).** Your orthodontic provider's information and signature is required for reimbursement.
3. You are responsible for retaining your previous year receipts for reimbursement. Please submit your receipts yearly in order to continue participating in the continual reimbursement program.

2a Orthodontic Expense Worksheet

$ Total treatment fee

$ Expected insurance coverage

☐ No Insurance Coverage

$ Initial payment *(if any)*

Date paid

$ Ortho records/model fee *(If separate from treatment fee)*

Date paid

$ Patients monthly payment (after expected insurance)

Date of First Payment

Expected # of months in treatment

$ Amount of last payment

☐ Orthodontic Treatment and Financial Agreement attached?

3 Continual Reimbursement

Expenses for orthodontia care may not be reimbursed under the plan prior to the time the 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 services are not rendered. It is your responsibility to advise the plan administrator of the cessation or interruption of such services.

4 Benefit Election

☐ Yes! Please sign me up for continual reimbursement of my orthodontia expense.

5 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 I am responsible for retaining copies of receipts for payment of these expenses, and they must be forwarded to National Benefit Services, LLC each year along with this form to continue participating in the continual reimbursement program.

Employee Signature

Date

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