

NBS Web Portal

How Do I Access My Online Account?

Registering for and logging into your account online is easy. Just follow the instructions below.

1 Get to the website

- ▶ Using your Internet browser, navigate to: <http://my.nbsbenefits.com>
- ▶ Click "Register" in one of the two locations on the home page. (Highlighted in red below.)

The screenshot shows the NBS Benefits Portal home page. At the top right, there are links for "Register" (highlighted in red) and "Login". Below the navigation bar, there is a search bar and a "Welcome to the NBS Benefits Portal" message. A central section titled "Take advantage of all the Resources" lists several services: 24/7 Account Access, Tools and Calculators, Frequently Asked Questions, Submit Claims Online, and NBS Mobile App. Below this list is a "LEARN MORE" button. At the bottom, there are three resource cards for HRA, FSA, and HSA, each with a "Click here to learn more" link. On the left side, there is a "Login" form with a "Continue" button and a "Forgot your Username? Click here" link. A red box highlights the text "New User? Please click here to create a username and password." in the "Login" section.

2 Complete the required fields of the registration form

- ▶ Username and password
- ▶ Personal information - name and email address
- ▶ Employee ID: Please enter your **Social Security Number**
- ▶ Employer ID OR NBS Benefits Card Number.
 - Employer ID is a 9 digit code given to you in your welcome email from NBS, or may be obtained through your employer or by contacting NBS at (855) 399-3035
- ▶ Accept the Terms of Use
- ▶ After completing all required fields, click "Register"

The screenshot shows a registration form with the following fields and options:

- User Name: * (required)
- Password: * (required)
- Confirm Password: * (required)
- First Name: * (required)
- Last Name: * (required)
- Email Address: * (required)
- Employee ID: * (required)
- Registration ID: * (required) with a dropdown menu set to "Employer ID" and an adjacent input field.
- Accept Terms of Use: * (required) with a checkbox and a link to "View Terms of Use".

At the bottom of the form are two buttons: "Register" (highlighted in blue) and "Cancel".

**If you have questions,
please call
(800) 274-0503**

Flexible Spending Account (FSA) Claim Form



Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must **include a date, description, and amount of the service**
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- **Please allow 2 business days for claims to be processed**

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

1 Personal Information

Employee Name _____	Company Name _____
Street Address, City, State, Zip _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Address Change?
Phone Number _____	Social Security Number _____

2 Dependent Care Expenses (Dates of Service are required in order to process claim)

	Date of Service		Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
	Start Date	End Date				
1	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____
Total Dependent Care Expenses						_____

3 Health Care Expenses

	Date of Service			Medical	Rx	Dental	Vision	Hospital	Ortho donta	Other Services: Please Specify	Person Receiving Service	Amount
	MM	DD	YY									
1	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
2	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
3	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
4	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
5	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
6	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
7	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
8	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
9	___	___	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
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 _____
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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)