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.

The following information can be found on our website under Forms at:
my.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.
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- **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.

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125 Cafeteria Plan Enrollment Form

Please complete this form and return it to your Human Resources Department

1 Personal Information

Employee Name (First Name, Last Name) | Company Name

Street Address | City | State | Zip Code | Social Security Number

Employee Phone Number | Date of Birth | Date of Hire (Required) | Email Address (Required to receive e-mail communications)

2 Benefit Election

☐ Initial Request Participation ☐ New Year Request ☐ Waive

If you are part of a company health insurance plan your 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: (**Required**) ☐ Bi-weekly (26) ☐ Weekly (52) ☐ Semi-monthly (24) ☐ Monthly (12)

☐ Health Care Expenses:
Must not exceed $2,550/year as per IRS regulations

Enrollment Effective Date (Required)

$ **Per pay period election (Required)**

$ Annual Election

☐ Dependent Care Expenses:
Maximum annual allowable election is $5,000 per year OR $2,500 per year if married and filing taxes separately

Enrollment Effective Date (Required)

$ **Per pay period election (Required)**

$ Annual Election

3 Debit Card (Health Care Expenses Only)

☐ I do not want a card.

☐ I already have a card and will continue to use it.

☐ I am new to the Plan – please send me a card

You will receive 1 card in your name. If you would like an additional card for a dependent, indicate their name here:

For replacement cards, card fees and/or additional dependent cards please contact HR or visit our website at my.nbsbenefits.com

4 Direct Deposit Request

☐ Checking Account
☐ Savings Account

Your Financial Institution

Financial Institution Address

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. If you have Direct Deposit information on file it carries forward unless corrected or rescinded in writing by you.

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

5 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

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Health Care Expense Worksheet

Instructions

This worksheet is for estimating annual health care expenses only.

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

1 Medical Care

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

2 Vision Care

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

3 Dental Care

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

4 Orthodontia Care

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

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NBS Prepaid MasterCard Card

The Smart Way To Pay For The Things You Need

1 The NBS® Prepaid MasterCard® 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 MasterCard credit cards, there's no need to pay cash up front and then wait for reimbursement.

2 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 MasterCard 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. Just swipe your card to pay for eligible items and then provide another tender for non-eligible purchases.

3 Approved Stores

Please see
http://sig-is.org/card-holders/store-locator
for a complete list of stores that accept the card.

4 Please Note

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.

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First Time Login

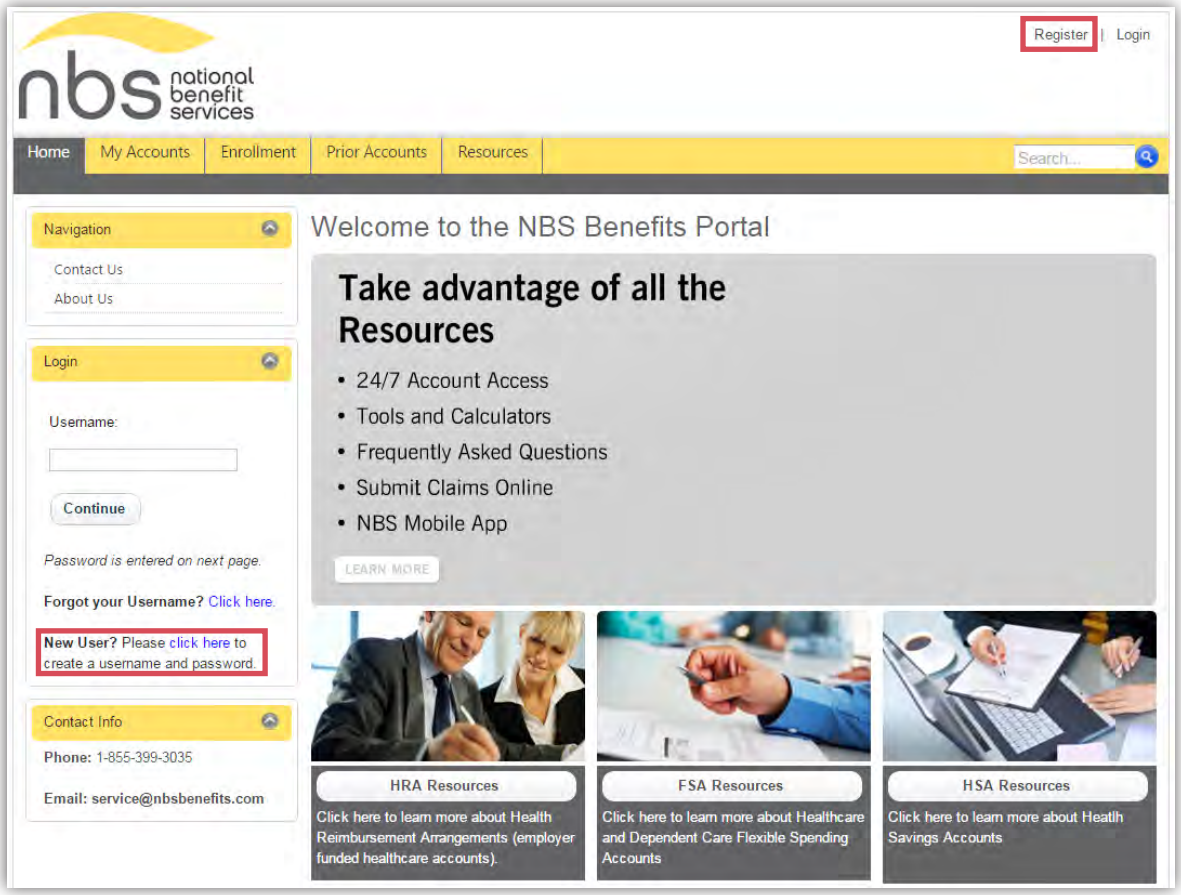
NBS Web Portal

How Do I Access My Online Account?

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

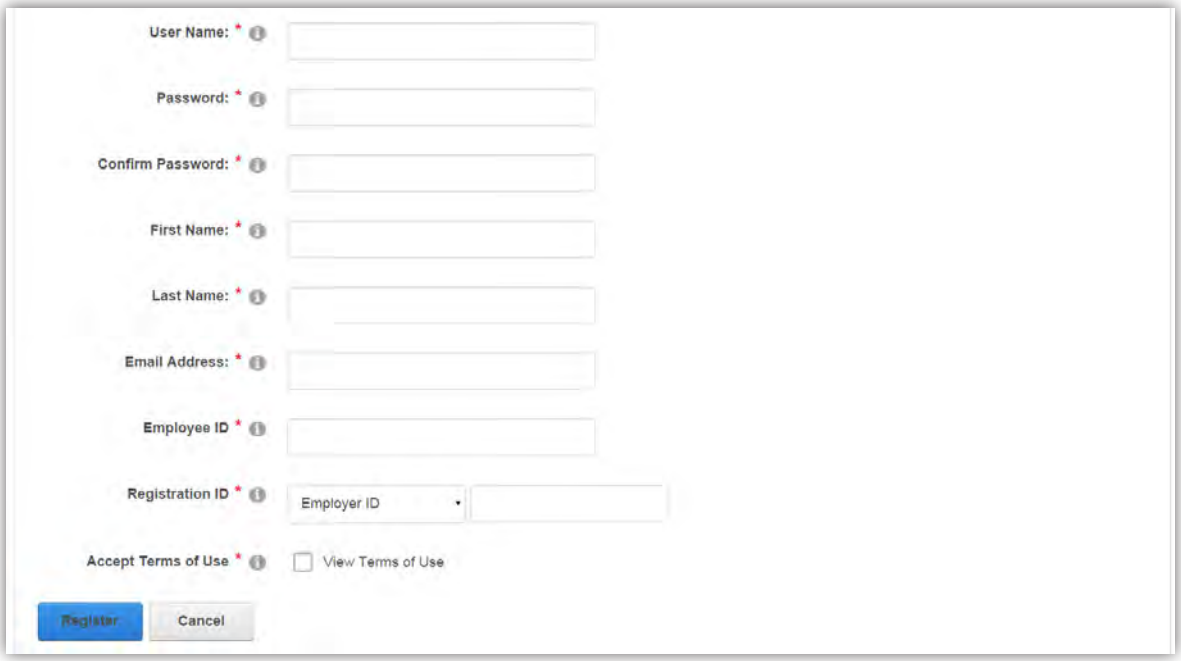
1 Get to the website

- 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.)



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”



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
- Minimum Total Reimbursement = $25
- Please allow 2 business days for claims to be processed

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

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

1 Personal Information

Employee Name _____ Company Name _____

Street Address, City, State, Zip _____ ☐No ☐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 Start Date	Date of Service End Date	Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
1						
2						
3						
4						

Total Dependent Care Expenses _____

3 Health Care Expenses

	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 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 _____

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)