

# 125 Cafeteria Plan Enrollment Packet

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The following information is found in this enrollment packet:

- 🕒 **Enrollment Form:** To sign up, please complete this form.
- 🕒 **Health Care Expense Worksheet:** This form will help you determine an amount that is right for you to have deferred into your Cafeteria Plan for medical expenses.
- 🕒 **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.
- 🕒 **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.
- 🕒 **Debit Card:** Information on the NBS Flex Card that allows you to charge your qualified medical expenses and when it can be used.
- 🕒 **Claim Form:** This form can be used to submit claims for reimbursement.
- 🕒 **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](http://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 Forms:** For submitting eligible medical and dependent care claims for reimbursement.

**Direct Deposit Request:** Have your reimbursements sent directly to your checking account.

Please complete the Enrollment Form in this packet and return it to your  
Human Resource Department.

(A new enrollment form must be completed each year for participation in the cafeteria plan.)

# 125 Cafeteria Plan Enrollment Form



(Please complete this form and return it to your Human Resource Department)

<b>Personal Information</b>	Company Name																										
	First Name								Last Name								Social Security Number - (Required)										
	Street Address												Date Of Birth - (Required)														
	City												State				Zip Code				Date Of Hire - (Required)						
Email Address (Required for ACH claim payment notification)												Phone Number															
<b>Benefit Election</b>	<p>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:</p> <p><input type="checkbox"/> <b>Health Care Expenses:</b>      \$ <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"/> PER YEAR  <small>Please refer to the SPD for the maximum annual allowable election</small></p> <p><input type="checkbox"/> <b>Day Care Expenses:</b>      \$ <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"/> PER YEAR  <small>Maximum annual allowable election is \$5,000 OR \$2,500 if married and filing taxes separately</small></p>																						<input type="checkbox"/> Initial Request  <input type="checkbox"/> New Year Request  <input type="checkbox"/> Waive Participation				
<b>Employee Signature</b>	<p>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</p>																										
	Employee Signature												Date														
X																											
<b>Direct Deposit Request</b>	Your Financial Institution												<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account														
	Financial Institution Address												Account Number														
													Routing Number														
	<b>IMPORTANT! Please attach a voided check with this form (not a deposit slip). Only for a savings account is a deposit slip acceptable.</b>																										
	<p>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.</p>																										
Employee Signature												Date															
X																											

NBS - 418(10/07)

National Benefit Services, LLC

P.O. Box 6980, West Jordan, UT 84084 PH (888)353-9125 Toll Free Fax (800) 478-1528

**Please return to your Human Resource department**

## Participant Account Web Access



National Benefit Services, LLC provides a website for participants to access account information. This site will give you:

- Access to detailed Claim History
- Health 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

To log on to your personal web account go to:

[www.NBSbenefits.com](http://www.NBSbenefits.com)

**First time users:**

USER ID: SS# (no dashes)

PASSWORD: Last four digits of your SS #

**Participant Summary**

Jon Doe

Expense Date	Claim Status	Service Provider	Claim Amount	Payment Amount	Payment Date	Additional Details
10/15/2004	Approved	Pharmacy	\$30.00	\$30.00	10/23/2004	<a href="#">View Details</a>
10/12/2004	Approved	Doctor	\$20.00	\$20.00	10/23/2004	<a href="#">View Details</a>
09/01/2004	Approved	Doctor	\$25.00	\$25.00	09/14/2004	<a href="#">View Details</a>

Address: 138 Martin Way  
Salt Lake City, UT 84111

Select plan year: 10/01/2004 - 09/30/2005

Benefit	Status	Declared Amount	Available Balance	YTD Deposits	Claims Submitted	Claims Rejected	Claims Paid
Dependent Care	Participating	\$3,000.00	\$0.00	\$75.00	\$125.00	\$0.00	\$75.00
Health Reimbursement	Participating	\$1,800.00	\$1,750.00	\$125.00	\$50.00	\$0.00	\$50.00

## Health Care Expense Worksheet

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

<b>Instructions</b>	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		
<b>Medical Care</b>	Insurance Deductibles	\$	_____
	Co-pays	\$	_____
	Routine Exams	\$	_____
	Prescriptions	\$	_____
	Lab Expenses	\$	_____
	Medical Equipment	\$	_____
	Chiropractor Visits	\$	_____
	Physical Therapy	\$	_____
	Other	\$	_____
	<b>Total Annual Medical Care Expense</b>	<b>\$</b>	<b>_____</b>
<b>Vision Care</b>	Eye Exams	\$	_____
	Glasses	\$	_____
	Prescription Sun Glasses	\$	_____
	Contacts	\$	_____
	Contact Lens Solutions	\$	_____
	Insurance Deductibles/Co-pays	\$	_____
	<b>Total Annual Vision Care Expense</b>	<b>\$</b>	<b>_____</b>
<b>Dental Care</b>	Cleanings	\$	_____
	X-rays	\$	_____
	Insurance Deductibles/Co-pays	\$	_____
	Fillings	\$	_____
	Crowns	\$	_____
	Other	\$	_____
	<b>Total Annual Dental Care Expense</b>	<b>\$</b>	<b>_____</b>
<b>Orthodontics</b>	Orthodontia	\$	_____
	Retainers	\$	_____
	<b>Total Annual Orthodontia Care Expense</b>	<b>\$</b>	<b>_____</b>
<b>Totals</b>	Total Annual Health Care Expense		
	\$	÷	= \$

# Dependent Care Expense Worksheet Continual Reimbursement Form



<b>Personal Information</b>	Employee Name		Company Name		
	Address		Social Security Number		
			Email Address		
<b>Instructions</b>	<p>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)</p> <ol style="list-style-type: none"> <li>1. Determine your per pay period election for dependent care expenses               <ol style="list-style-type: none"> <li>a. Enter the Total Annual Expense for dependent care</li> <li>b. Determine your yearly number of pay periods = weekly/52, bi-weekly/26, semi-monthly/24, monthly/12</li> <li>c. Divide the Total Annual Amount by the number of Pay Periods to calculate your Pay Period Deduction [Annual Expenses may not exceed \$5,000 (Married) and \$2,500 (If married and filing individual tax returns)]</li> </ol> </li> <li>2. For continual reimbursement please complete the Continual Reimbursement and Service Provider sections</li> <li>3. Please send the completed form to National Benefit Services, LLC</li> <li>4. <b>At the end of each quarter resubmit this form with prior quarter receipts to continue reimbursement</b></li> </ol>				
<b>Pay Period Election</b>	Total Annual Expense \$ _____ ÷	Number of Pay Periods _____ =	Pay Period Deduction \$ _____		
<b>Continual Reimbursement</b>	<p>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.</p> <p>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. <b>Receipts for Dependent Care must be received by NBS on a quarterly basis.</b></p>				
	<p><input type="checkbox"/> <b>YES! Please sign me up for continual reimbursement of my Day Care expense.</b> Your reimbursement will automatically be sent to you after each payroll period.</p>				
	<p>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. <b>I also understand that copies of receipts for payment of these expenses must be forwarded to NBS quarterly or continual reimbursement will cease.</b></p>				
	Employee Signature <b>X</b> _____		Date		
	<b>Service Provider Information</b>				
Care Provider Name		Date range of service (Maximum 1 year)			
		From Date _____	To Date _____		
Address					
I, the undersigned, hereby certify that the above person will/has incurred these expenses.					
Business ID # or Social Security #		Provider Signature			
		<b>X</b> _____			
<b>Quarterly Receipt and Continual Reimbursement Extension</b>	<b>1st Quarter Receipts</b>		<b>2nd Quarter Receipts</b>		
	Dependent Name: _____		Dependent Name: _____		
	Total Receipts: \$ _____		Total Receipts: \$ _____		
	Please continue my continual reimbursement for the next: <input type="checkbox"/> 3 Months <input type="checkbox"/> Other _____		Please continue my continual reimbursement for the next: <input type="checkbox"/> 3 Months <input type="checkbox"/> Other _____		
(Each quarter resubmit this form with the prior quarter's receipts for continued reimbursement)		<b>3rd Quarter Receipts</b>		<b>4th Quarter Receipts</b>	
		Dependent Name: _____		Dependent Name: _____	
		Total Receipts: \$ _____		Total Receipts: \$ _____	
Please continue my continual reimbursement for the next: <input type="checkbox"/> 3 Months <input type="checkbox"/> Other _____		Please complete a new form for the new year			

National Benefit Services, LLC

P.O. Box 6980, West Jordan, UT 84084 PH (801)838-7324 Toll Free (888) 353-9125  
FAX: Salt Lake City Area Fax: (801) 355-0928 Toll Free Fax: (800) 478-1528

# Flexible Spending Account (FSA) Health Care and Dependent Care Claim Form



<b>Personal Information</b>	Employee Name	Company Name
	Home Address	State of Hawaii
	Address Change <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Social Security Number <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>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>
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<b>Health Care Expenses</b> <small>(Please list one expense per line)</small>	Date of Service			Office Visit	RX	Dental	Ortho-dontia	Over the Counter Drugs	Vision	Other services please specify	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="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/> . <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/> . <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/> . <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/> . <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/> . <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/> . <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/> . <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/> . <input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="text"/> . <input type="text"/>
<b>Total Health Care Expenses</b>												<input type="text"/> . <input type="text"/>

<b>Dependent Expenses</b>	Date of Service			Child's Name	Age	Amount
	Mo	Day	Yr			
	<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"/>	<input type="text"/>			<input type="text"/> . <input type="text"/>
<b>Total Day Care Expenses</b>						<input type="text"/> . <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	
X	Employee Signature	Date

NBS - 402(07/08)

**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 or TIFF files only)

## HIPAA Privacy Notice

Effective Date: 1 April 2006

**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.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

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](http://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  
P.O. Box 6980  
West Jordan, Utah 84084