

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: <u>my.nbsbenefits.com</u>

- 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.
- > <u>Direct Deposit Request:</u> Have your reimbursements sent directly to your checking account.

125 Cafeteria Plan Enrollment Form

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



<u> </u>	_					
1 Personal Inf	formation					
Employee Name (First Name,	, Last Name)		Company Name			
Street Address		Chr	Ctato	Zin Codo	Cocial Cocurity Number	
Street Address		City	State	Zip Code	Social Security Number	
Employee Phone Number	Date	of Birth	Date of Hire (Red	quired)	Email Address (Required to receive e-mail communications)	
2 Benefit Elect	ion					
☐ Initial Request Participation	□ New Year Requ	uest \[\] Waive				
If you are part of a com the following benefits to			natically be paid p	ore-tax by payroll dedu	ction. You may also choose any of	
Number of pay periods	per year: (Required)	☐ Bi-weekly (26) ☐ We	eekly (52) 🗌 S	Semi-monthly (24)	Monthly (12)	
☐ Health Care Expense				\$	Per pay period election (Required)	
Must not exceed \$2,750 regulations	O/year as per IRS	Enrollment Effective Date (Required)		\$	_ Annual Election	
Dependent Care Expendent Care Expend		Enrollment Effective Date		\$	Per pay period election (Required)	
OR \$2,500 per year if married separately		(Required)		\$	_ Annual Election	
3 Debit Card (I	Health Care Ex	penses Only)			☐ I do not want a card.	
☐ I already have a	☐ I am new to the	You will receive 1 card in additional card for a dep	, ,			
card and will continue to use it.	Plan – please send i a card	ne For replacement card	ls, card fees an	 d/or additional depe	endent cards please contact HR or	
		vis	it our website a	at my.nbsbenefits.co	m 	
4 Direct Depos	sit Request				Chapling Assault	
Very Singuisia I Tarkituskia y					☐ Checking Account ☐ Savings Account	
Your Financial Institution						
Financial Institution Address						
Account Number			Routing Numb	per		
		Deposit information on f			savings account is a deposit rected or rescinded in writing	
		C to initiate credit entries and, int indicated above and the finar	if necessary, debi		es for any credit entries and	
Employee Signature				_	Date	
5 Employee Signature	nnature					
	_	s as my contribution(s) to the Cafet	eria Plan until chanc	ned by me in writing. Ire	cognize that such payroll reductions shall be	
adjusted automatically in the	ne event of a change in the enses under the plan, and	ne insurance premiums of the benef d understand I will be responsible to	its I have selected.	I will only use the Flexible	e Spending Account (including the use of a plan. In addition, I authorize the release of	
Employee Signature					Date	

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	\$						
		\$						
		\$						
	Prescriptions	\$						
	Lab Expenses	\$						
	Medical Equipment	\$						
	Chiropractor Visits	\$						
	Physical Therapy	\$						
	Other	\$						
	Total Annual Medical Care Expenses	\$						
2	Vision Care							
	Eye Exam	\$						
	Glasses	\$						
	Prescription Sun Glasses	\$						
		\$						
	Contact Lens Solutions	\$						
	Insurance Deductibles/Co-pays	\$						
	Total Annual Vision Care Expenses	\$						
3	Dental Care							
	Cleanings	\$						
		\$						
	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

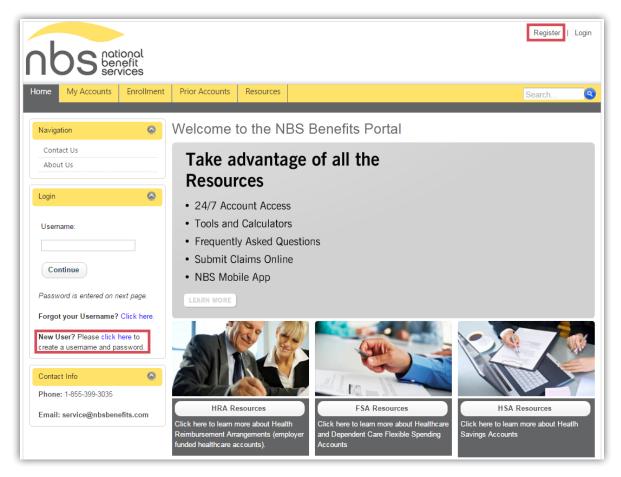


How Do I Access My Online Account?

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



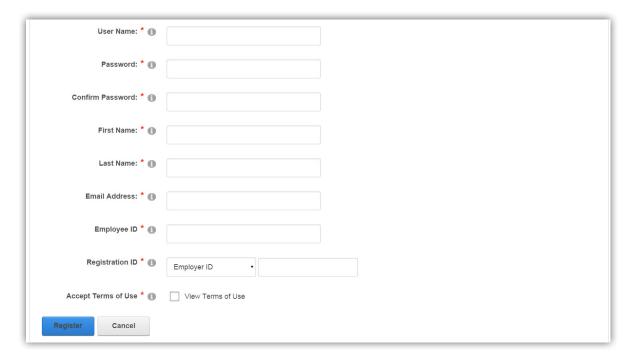
- Using your Internet browser, navigate to: http://my.nbsbenefits.com
- Click "Register" in one of the two locations on the home page. (Highlighted in red below.)





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
- Please allow 2 business days for claims to be processed

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

Employee Name								Compar	mpany Name			
Street Address, City, State, Zip										No Yes Address Change?		
one Num	ber					ocial Secur	ity Number					
2 De _l	Dependent Care Expenses (Dates of Dates of Service					f Service are required in order to process claim) Service Provider Tax ID#			A	A		
St	tart Date		End Da	ite			or SS#		Dependent's Name	Age	Amoun	
									Total Dependent	Care Expenses		
Hea	alth Care	Exper	nses									
MM	Date of Service DD	YY	Medical	Rx	Dental	Vision	Hospital	Ortho dontia	Other Services: Please Specify	Person Receiving Service	Amount	
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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)