



**State of Hawaii Island Flex  
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="checkbox"/> X <input type="checkbox"/> X <input type="checkbox"/> X - <input type="checkbox"/> X <input type="checkbox"/> X - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<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>▶ Reimbursement must total <u>at least \$25</u>, except at the end of the plan at which time it may be for less than \$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>

<b>Health Care Expenses</b> <small>(Please list one expense per line)</small>	Date of Service			Office Visit	RX	Dental	Vision	Over the Counter Drugs	Other Services: Please Specify	Person Receiving Service (Name/Relationship)	Amount
	Mo	Day	Yr								
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O	O	O	O	O			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O	O	O	O	O			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O	O	O	O	O			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O	O	O	O	O			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O	O	O	O	O			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O	O	O	O	O			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O	O	O	O	O			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O	O	O	O	O			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	O	O	O	O	O			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<b>Total Health Care Expenses</b>										<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>

If more lines are needed, you may use one claim form and attach an itemized listing on a separate sheet.

<b>Dependent Expenses</b>	Date of Service			Service Provider		Child's Name	Age	Amount
	Mo	Day	Yr	Tax ID # or SS#				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>
	<b>Total Day Care Expenses</b>							<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>

<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 while I was covered under the plan and will not be reimbursed or claimed under any other plan, claimed as a Tax Deduction or a Tax Credit. I understand that the IRS regards the date incurred as being when the service is rendered, and not when the bill is actually paid.	
Employee Signature X		Date

**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, TIFF or JPEG files only)