

Flexible Spending Account Claim Form

Employer: _____

Employee Name: _____ Employee or Social Security # : _____

Check here if new address Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Email: _____ Phone: _____

TO EXPEDITE YOUR CLAIM: Provide **ALL** appropriate information, including photocopies of receipts, and review the total dependent care and/or total health care expense amounts before submitting.

PLEASE NOTE: Any claim received **LESS THAN 24 HOURS** prior to your scheduled reimbursement date will be processed on the next scheduled reimbursement date.



You can also submit debit card receipts by filing your claim online at www.myflexonline.com (File A Claim). Then print the form & fax or mail it & the receipts to us!

Take Care® DEBIT CARD TRANSACTIONS			
Date of Service	Name of Service Provider	Expense Description	Amount
Take Care® Debit Card Transactions (to be substantiated)			\$

DEPENDENT CARE REIMBURSEMENT			
Name of Dependents	Period Covered From	To	Name, Address, and Taxpayer Identification Number of Service Provider
Provider's Signature (required if not on receipt)			Total Dependent Care Claims (to be reimbursed)
			\$

HEALTH CARE REIMBURSEMENT			
Date of Service	Name of Service Provider	Expense Description	Amount
View Your Account Online at www.myflexonline.com			Total Health Care Claims (to be reimbursed)
			\$

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Flexible Spending Benefit Plan with respect to such expenses and that the health expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the validity and accuracy of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. Please do not include original receipts, since, after the claim is substantiated, your receipts may not be readily accessible. **Claims will not be processed unless all above information is completed.**

Employee's Signature

Date

For immediate service, please fax to (513) 598-2901 or E-Mail to Flex@CustomDesignBenefits.com
 You may also mail to Custom Design Benefits, Inc., 3737 West Fork Road, Cincinnati, OH 45247
 For assistance, you may call (800) 598-2929 or (513) 598-2929