Mail Claims To:
Custom Design Benefits, Inc.
3737 West Fork Rd.
Cincinnati, OH 45247
Fax Claims To: (513) 598-2933
Ph: (800) 598-2929 Fax: (513) 598-2901
www.customdesignbenefits.com

Flexible Spending Account
Reimbursement Claim Form

Employer: ______________________ Social Security Number: ______________

Employee Name: ______________________ Date of Birth: ______________

Address: ____

E-mail Address ______________________ Phone: ______________

TO EXPEDITE YOUR CLAIM: PROVIDE *ALL* APPROPRIATE INFORMATION AND REVIEW THE TOTAL DEPENDENT CARE AND/OR TOTAL HEALTH CARE EXPENSE AMOUNTS BEFORE SUBMITTING YOUR CLAIM.

Name of Dependents	Period Covered From	Period Covered To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
➢ *Attach a receipt from your daycare provider, or include the daycare provider's signature.*			Provider's Signature:	
			Total Dependent Care Expense Claim*	$

* PLEASE NOTE ANY CLAIM RECEIVED LESS THAN 24 HOURS PRIOR TO YOUR SCHEDULED REIMBURSEMENT DATE WILL BE PROCESSED ON THE NEXT SCHEDULED CHECK REIMBURSEMENT DATE.

Health Care Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Claimant Name	Net Amount
➢ *Attach appropriate receipt(s) and submit with this claim form.*			**Total Health Care Expense Claim**	$

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 Cafeteria 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 sufficiency, accuracy, and veracity 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.

______________________ Employee's Signature

______________________ Date

View your account on line at www.customdesignbenefits.com or call our 24-hour voice response system at (866) 598-2939.