



Custom Design Benefits
FSA CLAIM FORM
 (Flexible Spending Account)

Submit Claims To:

Custom Design Benefits, Inc.
 5589 Cheviot Road
 Cincinnati, Ohio 45247
 Ph: (800) 598-2929
 Fax: (513) 598-2901

FlexClaims@CustomDesignBenefits.com

Employer: _____

Employee Name: _____ Employee or Social Security #: _____

Check here if new address Address: _____

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

Email: _____ Phone: _____



IMPORTANT!

When using the FSA Card, please do NOT mail anything in unless requested to do so. Most items will be automatically approved. Please keep copies for your records.

CHANGES FOR OVER-THE-COUNTER MEDICATIONS. If your physician prescribes an Over-the-Counter medicine to take ongoing, such as DAILY aspirin or antihistamine, please submit a copy of the prescription with the claim for faster claims processing. If you have already provided a copy of the prescription with a prior claim and need us to access history, please check this box:

DEPENDENT CARE REIMBURSEMENT				
Name and Age of Dependent(s)	Period Covered		Name, Address & Taxpayer Identification Number of Service Provider	Claim Amount
	From	To		
Provider's Signature (required if not on receipt):			Total Dependent Care Claims	

TO ENSURE WE CAN PROCESS YOUR CLAIM: Provide **proper supporting documentation**, including copies of bills indicating name of provider, name of patient, service/product provided, date the service was provided and amount of the expense not covered by other insurance. Please note: credit card statements do not contain enough info for submitting claims.

HEALTH CARE REIMBURSEMENT				For expenses not paid using the <i>Take Care</i> FSA Card	
Patient Name and Relationship	Date of Service		Name of Service Provider and Description of Expense	Claim Amount	
	From	To			
Total Health Care Claims					

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 Signature

Date

View your account, including the status of your claim, online at www.MyFlexOnline.com.

More information & resources are available at www.CustomDesignBenefits.com