Custom Design Benefits

www.CustomDesignBenefits.com

Health Reimbursement Account - Claim Form

Employer: _____

Employee: _____ Employee or S.S. #: _____

☐ Check if new address Address: _____

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

E-mail address_____ Phone: _____

TO EXPEDITE YOUR CLAIM:
Provide ALL information and review the total healthcare expense amounts before submitting you 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.

TO ASSURE ACCURATE REIMBURSEMENT, YOU MUST **ATTACH A COPY OF YOUR EXPLANATION OF BENEFITS (EOB)** OUTLINING THE ACTUAL EXPENSE AMOUNT TO BE PROCESSED. THIS MUST BE PROVIDED FOR EACH CLAIMANT LISTED FOR A REIMBURSEMENT ON THIS CLAIM FORM.

HRA Unreimbursed Health Expense Claims ☐ **If you would like the balance submitted to your FSA, please check the box**

Date Expense Incurred	Name of Service Provider	Expense Description	Claimant Name	Net Amount

➢ *Attach appropriate receipt(s) and submit with this claim form.* **View Your Account Online at www.myflexonline.com** **Total Health Care Expense Claim $**

Read Carefully: The undersigned participant in the Plans 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 Plans 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 Plans which relate to such expense.

_____ _____
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