Transit/Parking FSA CLAIM FORM

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 Number: __________________________

☐ Check here if new address Address:____

City:____________________________________ State:___________ Zip:_______________ Date of Birth:_____________________

E-mail Address____ Phone: __________________________________

TO EXPEDITE YOUR CLAIM: Please provide appropriate information, **INCLUDING PHOTOCPOIES AND RECEIPTS**. Claims received less than 24 hours prior to the scheduled reimbursement date will be processed on the next scheduled reimbursement date.

Qualified Parking Garage & Meter Expenses

Date From (MM/DD/YYYY)	Date To (MM/DD/YYYY)	Amount of Reimbursement	Metered Parking? (Check one)	If no, please provide Parking Facility Name
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	

I hereby certify that I have incurred the expenses indicated above and any additional burden of proof will remain my responsibility if I am required to provide substantiation.

Employee Signature: Date:

Qualified Mass Transit & Auto Share Expenses

Date From (MM/DD/YYYY)	Date To (MM/DD/YYYY)	Amount of Reimbursement	Bus Fare? (Check one)	If no, please provide Mass Transit or Auto Share Provider
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	

I hereby certify that I have incurred the expenses indicated above and any additional burden of proof will remain my responsibility if I am required to provide substantiation.

Employee Signature: Date:

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 expenses have not been reimbursed or are not reimbursable under any other 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. Please do not include original receipts since, after the claim is substantiated, Custom Design Benefits does not keep receipts on file.

____ ____________________________

Employee's Signature **Date**

See www.CustomDesignBenefits.com and login to MyFlexOnline to view claims and other information.