Custom Flex HRA Portal & Mobile App

ONLINE PORTAL

Go to **www.CustomDesignBenefits.com**. Click on **Member Portal**.

Click on **Custom Flex: FSA/HRA/HSA** to log onto the Custom Flex Portal.

If you are logging in for the first time, your User Name is the first initial of your first name, your last name, followed by the last four digits of your Social Security Number. For example, John Smith, who has a Social Security Number of 333-55-9999, would have a User Name of jsmith9999. Your default password is Customflex and you will be prompted to change it the first time you log in.

User Name: FirstInitialLastNameLast4SSN

Password: Customflex

The claim filing wizard will walk you through the process to file a claim, including entry of your information, payee details and uploading a receipt.

You may print the Claim Confirmation Form as a record of your claim submission.

The Custom Flex Portal also allows you to

- View your account balance
- View your claims history
- Request a new card
- Update your personal profile information
- Change your login ID and/or password.

Be sure to sign up for email notifications!

MOBILE

After you have logged in to the Custom Flex Portal for the first time, you can download the FREE Mobile App for Android and Apple devices. Search for "Custom Flex" in the App Store.

Available on the Android App Store

Available on the App Store

EMAIL

Complete the HRA Claim Form & attach scanned documentation to the email.

You may also use this email address for all other questions and forms.

CustomFlex@CustomDesignBenefits.com

FAX

Complete the HRA Claim Form & fax with documentation. 513.598.2901

MAIL

Complete the HRA Claim Form & mail with documentation

(Please keep copies of your documentation.)

Custom Design Benefits
5589 Cheviot Road
Cincinnati, OH 45247

QUESTIONS?

513.598.2929 Local Cincinnati
800.598.2929 Toll-Free

Custom Design Benefits

Employee Authorization for Direct Deposit

Submit Form To:
Custom Design Benefits, Inc.
5589 Cheviot Road
Cincinnati, Ohio 45247
Ph: (800) 598-2929
Fax: (513) 598-2901
customflex@CustomDesignBenefits.com

Please check one of the boxes below (allow 1-2 pay periods for processing):

- ☐ **ADD** Please deposit my reimbursements into the bank account listed below
- ☐ **CHANGE** I would like to change the account where my current direct deposit reimbursement is sent
- ☐ **CANCEL** I would like to stop sending funds directly to my account and have future funds by check mailed to me at the address on file.

Employer Name: _____

Employee Name: _____ Employee SSN or #: _____

Financial Institution: _____

Branch: _____ City: _____ State: _____ Zip: _____

Bank Routing Number (9 digits):_____

Checking Account _____or Savings Account _____

I hereby authorize Custom Design Benefits, Inc. to initiate credit entries to the checking account indicated on this form as the depository financial institution for transactions related to my Flexible Spending Account or Health Reimbursement Account. Additionally, I authorize the Company to initiate any necessary debit reversal entries only for the correction of erroneous or duplicate entries previously credited to my account indicated on this form. It is acknowledged that the origination of ACH transactions to my account must comply with the provisions of United States law.

This authorization is to remain in full force and effect until Custom Design Benefits, Inc. has received written notice of its termination in such time and in such manner to afford Custom Design Benefits, Inc. and the financial institution a reasonable opportunity to act on it.

Authorized Signature: _____ **Date:** _____

ATTACH A VOIDED CHECK FROM THE ACCOUNT HERE

A voided check should be attached so there is no question as to the bank and account where funds are to be debited or credited.

For assistance, call **800.598.2929** or (for local Cincinnati area) **513.598.2929**

Custom Design Benefits

HRA Claim Form

Health Reimbursement Account

Submit Claims To:
Custom Design Benefits, Inc.
5589 Cheviot Road
Cincinnati, Ohio 45247
Ph: (800) 598-2929
Fax: (513) 598-2901
CustomFlex@CustomDesignBenefits.com

Employer: _____

Employee: _____ Employee or SSN #: _____

☐ Check if new address Address: _____

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

E-mail: _____ Phone: _____

TO ENSURE WE CAN PROCESS YOUR CLAIM:

ATTACH A COPY OF THE EXPLANATION OF BENEFITS (EOB) -- This must be provided for each patient. The EOB should also show your year to date totals that have applied toward your deductible and out of pocket expenses.

Please note that cash register receipts, balance due bills and credit card statements do NOT have enough information for submitting claims.

CLAIMS RECEIVED LESS THAN 24 HOURS PRIOR TO THE PLAN'S SCHEDULED CHECK ISSUING DATE WILL BE PROCESSED ON THE NEXT SCHEDULED DATE.

HRA REIMBURSEMENTS REQUESTED

Date of Service	Name of Service Provider	Service Description	Patient Name	Claim Amount
			Total Amount of HRA 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

To view claims and other account information visit www.CustomDesignBenefits.com, click Member Portal, then FSA/HRA/HSA.