Using Custom Flex

Instructions for Filing a Claim

FSA CARD USERS

Please do not send documentation unless you receive a communication from CDB. Nearly 80% of FSA Card transactions do not require anything further.

ONLINE

- Go to **www.CustomDesignBenefits.com** and click Member Portal.
- Click on Custom Flex: FSA/HRA/HSA.
- Follow prompts to complete your claim electronically.

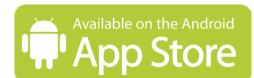
  User Name: First initialLastNameLast4SSN ... example: jsmith9999
  Password: Customflex
- You may file a claim, check account balances, review claims history and shop the FSA Store.
- Upload documentation and submit.
- Retain a copy for your records.

MOBILE

Mobile app available for Android and Apple devices.

FREE download from the App store
(Search for "CustomFlex").

Use the app's Eligible Expense Scanner so you know before you buy.



EMAIL	Complete the FSA Claim Form & attach scanned documentation to the email. You may also use this email address for all other questions.	CustomFlex@CustomDesignBenefits.com
FAX	Complete the FSA Claim Form & Fax with documentation.	513.598.2901
MAIL	Complete the FSA Claim Form & mail with documentation. (Please keep copies of your documentation)	5589 Cheviot Road Cincinnati, OH 45247
QUESTIONS?	513.598.2929 Local Cincinnati	800.598.2929 Toll-Free

More Information

To learn more about FSAs, visit our website at www.CustomDesignBenefits.com.

- **Qualified Expenses** – Review a summary of expenses that qualify for FSA savings. A more detailed list is available to FSA participants by logging in to Custom Flex.
- **Forms** – Print forms or download electronic forms that can be emailed with claims.
- **Frequently Asked Questions** – Answers to common questions about FSAs.

Once you become an FSA participant, you can review your account online. From our home page, click on Member Portal, then click on Custom Flex: FSA/HRA/HSA to log into Custom Flex.

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
CustomFlex@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 approved automatically. Please keep copies for your records.

Get your money faster...Sign up for Direct Deposit!
Simply visit our Custom Flex web portal to sign up, or complete and return a direct deposit form to the email or address above. The form is located on our website, www.CustomDesignBenefits.com, click 'Members' and see Forms section.
*Not all Flexible Spending Accounts utilize direct deposit, so check with your employer to see if this option is available.

DEPENDENT CARE REIMBURSEMENT

Name and Date of Birth of Dependent(s)	Period Covered From	To	Name, Address & Taxpayer Identification Number of Service Provider	Claim Amount
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 FSA Card

Patient Name and Relationship	Date of Service From	To	Name of Service Provider and Description of Expense	Claim Amount
			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

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

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**