Custom Design Benefits

City of Cincinnati & Custom Design Benefits

Flexible Spending Account & Health Reimbursement Account
Reimbursement Form

Submit Request To:
Custom Design Benefits, Inc.
5589 Cheviot Road, Cincinnati, Ohio 45247
Ph: (800) 598-2929
Fax: (513) 598-2901 (No cover page needed)
FlexClaims@CustomDesignBenefits.com

Employee Name: ______________________________ Employee or Social Security #: ____________________

☐Check here if new address Address: ____

City: ____________________ State: __________ Zip: __________ Date of Birth: ______________

Email: ______________________________ Phone: ______________________________

HEALTH CARE REIMBURSEMENT				
Patient Name and Relationship	Date of Service		Name of Service Provider and Description of Expense	Claim Amount
	From	To		
			Total Health 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.

DEPENDENT CARE REIMBURSEMENT				
Name and Age 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**	

CLAIMS MUST BE SUBMITTED IN A TIMELY MANNER.

- Medical FSA and Dependent Care claims must be submitted by **March 31 of the following year**.
- **If employment is terminated** for any reason, all services must be rendered prior to the last day of employment to be eligible for reimbursement. Any claims must be submitted within 90 days of the last day of employment or monies remaining in your account will be forfeited.

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