# CBIZ Flex

## Flexible Benefits Plan Claim Form

*Version 11.01.08*

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|---|---|---|---|
| **Employer:** | | | |
| **Employee:** | | **SSN:** | - - |
| **Email:** | | **Phone:** | ( ) - |

### Un-reimbursed Medical Expense Claims

| Date Expense Incurred | Name of Service Provider | Expense Description | Person for Whom Expense Incurred | Net Amount |
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*~Attach appropriate receipt(s) and submit with this claim form.* **Total Medical Care Expense Claim**

### Dependent Care Expense Claims

| Name of Dependents | Period Covered From | To | Name and Taxpayer Identification Number of Service Provider | Amount Incurred |
|---|---|---|---|---|
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*~Attach appropriate receipt(s) and submit with this claim form.* **Total Dependent Care Expense Claim**

**Provider's Signature** _____

### Read Carefully

The undersigned participant in the Plan certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the company's Flexible Benefits Plan with respect to such expenses, and that the medical or dependent care expenses have not been reimbursed or are not reimbursable under any other health plan coverage and that they were incurred by the participant or a legal dependent of the participant. The expenses qualify as valid Medical Care Expenses under Code 213(d), as defined in the Flexible Spending Account Summary Plan Description Document ("the plan"). The undersigned certifies that their family member has received the services described above on the dates indicated, and the expenses qualify as valid Dependent Care Expenses as defined in the FSA Summary Plan Description Document. The undersigned fully understands that he or she 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, and or local income tax on amounts paid from the Plan which relate to such expense.

_____ _____

**Employee Signature** **Date**

**Claim Forms can be mailed or faxed to:**

CBIZ Payroll, Attn: Flex 310 First St., Ste 600 Roanoke, VA 24011 *(Please keep a copy for your records)*

Fax: **800-584-4185** Phone: 800-815-3023 option 4 Email: cbizflex@cbiz.com