



# CBIZ Flex

## Flexible Benefits Plan Claim Form

Version 10.01.07

<b>Employer:</b>			
<b>Employee:</b>		<b>SSN:</b>	- - -
<b>Email:</b>		<b>Phone:</b>	(   )   -

### Un-reimbursed Medical Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount

<i>~Attach appropriate receipt(s) and submit with this claim form.</i>	<b>Total Medical Care Expense Claim</b>
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### Dependent Care Expense Claims

Name of Dependents	Period Covered From To	Name and Taxpayer Identification Number of Service Provider	Amount Incurred

<i>~Attach appropriate receipt(s) and submit with this claim form.</i>	<b>Total Dependent Care Expense Claim</b>
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<p style="text-align: center; border-top: 1px solid black; margin-top: 20px;"><b>Provider's Signature</b></p>	<p><small>*The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of him/herself, then he/she is deemed to have a monthly income of \$200 if there is one (1) child or dependent, and \$400 if there are two (2) or more children or dependents.) No payment may be made under the Plan if the service provider is your dependent for Federal Income Tax purposes, or is your child or stepchild and is under the age of 19.</small></p>
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### 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 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 Salary Reduction Plan Document ("the plan") (and, if I elected the Limited (Vision/Dental/Preventive Care) Health FSA Coverage Option, the expenses also qualify as being services or treatments for vision care, dental care, or preventive care, as described in the Plan). These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries. 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 Salary Reduction Plan document ("the plan"). 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.

<b>Employee Signature</b>	<b>Date</b>
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**Election and 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](mailto:cbizflex@cbiz.com)  
 Visit [www.myflexonline.com](http://www.myflexonline.com) to submit claims, verify receipt, or check account balance.