Flexible Benefits Claim Form

For account balance, go to myplans.cbiz.com or call (800) 815-3023, option 4.

Instructions for claims processing:

1. Fully complete and sign the claim form – please allow at least 2 business days from receipt for claims to be processed
2. Attach copies of supporting EOB, receipts, bills, etc. – **all receipts must include** date, description, and cost of service
3. Please list one expense per line
4. If filling out by hand, please print legibly in black or blue ink
5. Email or fax completed form to: Email: cbizflex@cbiz.com | Fax: (800) 584-4185

For faster claims processing, file claims online or through our mobile app:

- Log in to the consumer portal at myplans.cbiz.com and select *File a Claim* under the *Accounts* link
- Download the mobile app through the Apple or Google Play store and search for *My Plans by CBIZ*

*Required Fields

PART I | Consumer Information

*Consumer Name (First, MI, Last)	*Employer Name	
*Email Address	*Phone Number	*Social Security Number

PART II | Claim Information

Date Expense Incurred	*Service Provider	Service	Name of Person Receiving Service	Plan Type	Cost
				Total	$ 0.00

If submitting a Dependent Care Claim, please include the Tax Identification number and ensure your provider has signed under Provider's Signature in lieu of any receipts.	*Provider Signature

PART III | Signature

Healthcare FSA: I, the undersigned, certify that I, my spouse, or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care and are not for cosmetic purposes. I understand that "incurred" means the service has been provided.

Dependent Care FSA: I, the undersigned, certify that I have incurred the Dependent Care expenses for me and, if married, my spouse to work. These expenses are for my Qualifying Dependent. These qualify as eligible expenses under my plan and are not for educational expenses to attend kindergarten or higher. I understand that "incurred" means the service has been provided. These are regardless of when I am billed or charged for or pay for the service.

Parking FSA: I, the undersigned, certify that I have incurred each expense on this form, and are eligible expenses under my plan.

HRA: I, the undersigned, certify that I, my spouse, or eligible dependent have incurred each expense on this form. These expenses are eligible under my plan. I understand "incurred" means the service has been provided.

I understand that if any information is missing or incorrect on the claim form or supporting documents the claim will be denied and must be resubmitted with the corrected/missing information. I certify that I have not received prior reimbursement for any of these expenses and I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return.

*Consumer Signature	*Date