FLEXIBLE BENEFIT MANAGEMENT

Flex Spending Claim Form

Claims processed every Monday of every week

To send in your claim – complete each section and email: cristy@custombenefits.work

Need help? Call Cristy Gupton 828-413-3581

Section 1: Identification

Your name: ______ ______ ______

first middle initial last

Email address: ______

Employer name: ______

Section 2: What type of reimbursement are you requesting?

Medical Amount Daycare Amount

$ ______ $ ______

How do we reimburse it?

☐ DIRECT DEPOSIT to my Bank (processed every Monday)

☐ Send CHECK by U.S. mail

Section 3: List the expenses you have incurred with required details and validate by signing

Family member receiving service	date of service	description and location of service	cost of service

My statements are true and complete and my claim is for expense during the Plan Year for which I have not or will not be reimbursed. I have all the appropriate receipts and documentation to support the requests made on this page.

Employee Name: ______ Date: ______