# How to File a Claim

Please mail or fax your claims to the address below:

CBIZ Payroll, Inc.
Attn: Flex Claims Administrator
P.O. Box 20
Roanoke, VA 24002
Fax: 540.345.3666
Phone : 800-815-3023
Option #4 for Benefit Services
Email : BenefitServices@cbiz.com

If mailing your claim, please allow plenty of time for the postal service to deliver your claim. All completed claims must be received by Thursday at 2:00 PM EST to be processed and mailed on Friday.

## Completed claims consist of:

1. A completed and signed claim form. This is the authorization to disburse money from your account. *(Please be sure to include Employer, Name, and S.S.N.)*

2. Any claim must be accompanied by receipts that include amounts charged, dates services were provided, description of services rendered and for whom they were provided. IRS regulations do not permit monthly statements as proof of service.

## Please be sure to call our processing center if:

1. You do not receive a disbursement check within 15 days of mailing a claim to us.
2. You have any change in address.
3. You have any questions regarding payments received.

For checks that are sent to the wrong address, lost, stolen, or mishandled, a stop payment can be issued 14 days past the check date for a service charge of $25.00.

# *2 ½ Month Extension Claim Form*

**Mail claim form with receipts to: CBIZ Payroll, Inc., P.O. Box 20, Roanoke, VA 24002 or Fax to: 540.345.3666 (Phone #800-815-3023 option #4 for Benefits)**

| | |
|---|---|
| **Employer:** | |
| **Employee:** | |
| **SocSec #:** - - | |

## Unreimbursed Medical Expense

| Date of Service | Name and Address of Service Provider | Expense Description | Person for Whom Expense Paid | Amount Paid |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | **Total Claim** | $ |

## Dependent Care (Day Care) Expense

| Name of Dependent | Period Covered From | To | Name Address and Taxpayer ID Number of Provider | Amount Paid |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | ***Total Care Claim** | $ |

**Signature of Day Care Provider** **Date**

*DEPENDENT CARE EXPENSE NOTE - 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 or 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.

## 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. 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**