P&A Group

FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Today's Date: _____/_____/_____ **# of pages:** _____ **Plan year beginning for:** 200___

☐ New Claim ☐ Resubmission of claim ☐ Response to claim denial

Employer Name/Division Name:	Employee Name:	
Address: ☐ Please check if change of address		
Social Security Number:	E-mail Address:	Home Phone: Work Phone:

Please note: Not all these accounts may apply to your group

☐ **Medical Expense Reimbursement Account** **Total Amount Requested**_____

- Enclose insurance company statement or itemized bill from provider showing date of service, services rendered, provider of service, amount paid and, if applicable, amount covered by insurance.
- Prescription claims **MUST** include the RX number and pharmacy receipt, not cash register receipt.
- Allowable reimbursement for mileage expenses

☐ **Dependent Care Reimbursement Account** **Total Amount Requested**_____

Must include provider Tax ID Number

☐ **Individual Premium Reimbursement Account** **Total Amount Requested**_____

Please attach proof that employee owns policy

☐ **Adoption Assistance Reimbursement Account** **Total Amount Requested**_____

Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service (Rx copay, dental, etc.)	Service Provider/ Rx # (MUST be provided)
1.				
2.				
3.				
4.				
5.				

If you are unsure if an expense is eligible for reimbursement, please call P&A's Flex department at 716-852-2811 or 800-828-2811
Please note the following requirements for claims submission:

- Please number each receipt according to its order of appearance on this form.
- IRS guidelines do **NOT** consider cancelled checks as valid documentation.
- Previous balances are **NOT** acceptable.
- All reimbursements will be made payable to the employee.

To the best of my knowledge and belief, my statements in this reimbursement voucher are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed on this or any other benefit plan and WILL NOT BE CLAIMED AS AN INCOME TAX DEDUCTION. I authorize my Flexible Compensation account be reduced by the amount released.

EMPLOYEE'S SIGNATURE_____ DATE_____

For faster service, fax claims to: (716) 855-7105 or (877) 855-7105

Or mail to: Flex Department, 17 Court Street, Suite 500, Buffalo, NY 14202-3204 • Visit our website to access account information at www.padmin.com