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 R_X number 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**_____

❑ **105(h)/Health Reimbursement Account** **Total Amount Requested**_____

Date of Service	**E**mployee, **S**pouse or **D**ependent	Amount Requested	Type of Service (R_X copay, dental, etc.)	Service Provider/ R_X # (**MUST** be provided)
1.				
2.				
3.				
4.				
5.				

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 requested.

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

Rev. 11/9/2004

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

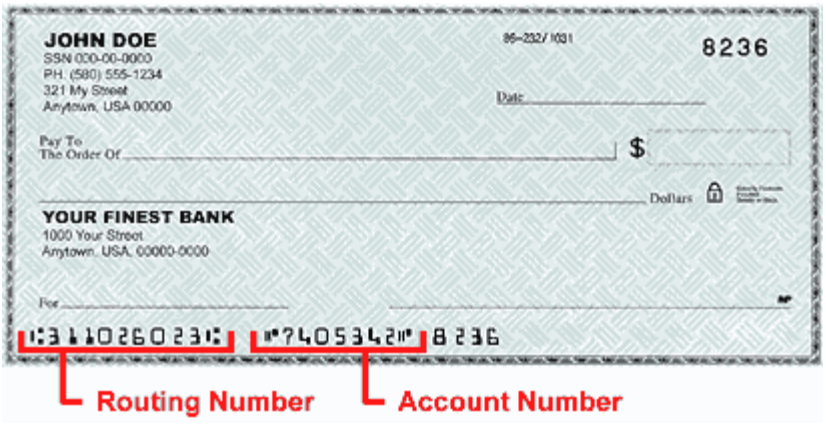
You can now have your Flexible Spending Account and/or Transportation claim reimbursements deposited directly into your bank account. Please complete the following information below to setup direct deposit.

Bank Name _____

Transit (ABA) No. _____ Account No. _____

Please indicate type of account (circle one) CHECKING or SAVINGS
If this is a new account, it must be established and active at your bank before you request direct deposit.

Please attach a voided check for checking, or a deposit slip for savings account



[Attach check / slip here]

I authorize P&A Administrative Services, Inc. and the bank listed above to deposit my Section 125 and/or Section 132 claim reimbursements directly into my bank account listed above.

If funds to which I am not entitled are deposited to my account due to error or any other reason, I authorize P&A Administrative Services, Inc. to direct the bank to return said funds to P&A Administrative Services, Inc.

I understand that my deposit may not be credited to my account for up to 2 business days after the transaction has been sent to the bank for processing.

Employer Name _____

Employee Name _____ SSN# _____

(Please Print)

Work Phone No. _____ Home Phone No. _____

Employee Signature _____ Date _____

I understand that this authorization will remain in effect unless I advise P&A that I have revoked it. Furthermore, I understand that it is my responsibility to notify P&A of all future changes to my bank account number and routing number. If I fail to notify P&A of changes of this nature, I will be responsible for reimbursing P&A for all applicable bank charges.

Please fax this completed form to P&A via toll-free number: 1-877-855-7105
or mail to: Attn – Flex Dept., 17 Court Street, Suite 500, Buffalo, NY 14202