Flexible Spending Account Claim Form

Today's Date:___/___/_____ # of pages: _____ Plan Year: 20_____ ❑ New Claim ❑ Response to Claim Denial

Employee Name	**Employer Name/Division Name**	
Employee Address		
Social Security Number of Member ID Number	Work Phone	Home Phone

Account	**Reimbursement Amount**
☐ Health Flexible Spending Account	Total Amount Requested _____
☐ Dependent Care Flexible Spending Account Dependent Care Provider Signature: X _____ NOTE: *You must include the provider Tax ID Number in the services provider column in the table below. If you use the account to pay for the cost of a babysitter, you must provide the babysitter's Social Security Number. If you cannot remit a copy of your bill/contract, your daycare provider must sign on the line below in lieu of submitting a receipt. In addition, as to the dependent care expenses identified above (if any), I meet each of the certifications at "Qualifying Care Expense Certifications on page 2."* Employee Signature: X _____	Total Amount Requested _____
☐ Individual Premium Reimbursement Account *For reimbursement from this account, please attached proof of the non-employer sponsored policy.*	Total Amount Requested _____
☐ Adoption Assistance Account	Total Amount Requested _____

Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service (Rx, co-pay, dental)	Service Provider/Rx Number
1.				
2.				
3.				
4.				
5.				

Minimum check reimbursement is $25; minimum reimbursement for direct deposit is .50

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: ___/___/___

Claim Submission Guidelines

- 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.

Claim Submission

- Fax: Toll-free (877) 855-7105 or (716) 855-7105
- Mail: Att: Flex Department 17 Court Street, Suite 500 Buffalo, N.Y. 14202-3204

Qualifying Care Expense Certifications

1. The dependent care expenses identified on page 1 were incurred for the care of only one or more Qualifying Individuals. I understand that only the following persons are Qualifying Individuals for this purpose.

    a. a person under age 13 who is my "qualifying child" under the Internal Revenue Code (the "Code"), i.e., (1) he or she has the same principal residence as me for more than half the year, (2) he or she is my child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) he or she does not provide more than half of his or her own support for the year.

    b. my spouse if he or she is physically or mentally incapable of self-care and has the same principal abode as me for more than half the year.

    c. a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as me for more than half of the year, and is my tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

    d. if I am divorced or separated, my child but only if I am the primary custodial parent (irrespective of whether which parent may claim a personal exemption for the child on his or her federal income tax return).

2. The expenses were incurred to enable me (and my spouse, if any) to be gainfully employed. If spouse is not employed, I certify my spouse is incapacitated or a full-time student.

3. The expenses were for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.

4. To the extent that the expenses were for services outside of my household for the care of a Qualifying Individual other than a person under age 13 who is my qualifying child, that Qualifying Individual regularly spends at least eight hours per day in my household.

5. To the extent that the expenses were for services provided by a dependent care center (including a day camp), the center complies with all applicable state and local laws and regulations.

6. None of the expenses were for dependent care services provided by my spouse, by a parent of my under-age-13 qualifying child or by a person for whom I or my spouse is entitled to a claim a personal exemption on a federal income tax return.

7. In the case of any expenses for dependent care services provided by a child of mine, that child will be at least 19 years old at the end of the year in which the services were provided.

8. None of the expenses were for services or attendance at an overnight camp.

P&A Group Customer Service

- Hours: Monday – Friday, 8:30AM – 10:00PM ET
- Website: www.padmin.com
- Toll-free: (800) 688-2611