FSA Claim Form

P&A GROUP EST. 1975

Submit this completed claim form via fax or mail.
If you have any questions call (716) 362-5595 or (866) 916-3475.
Fax: (877) 213-8917
Mail: P&A Group Attn: NC FSA Plan 6400 Main Street, Suite 210 Williamsville, NY 14221.

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STATE INSURANCE PLANS
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Today's date:__/__/__ ____ # of pages Plan Year beginning for: 20____ ❑ New claim ❑ Re-submission of claim ❑ Response to claim denial

Employee Name:	FSA ID Number or Social Security Number:	
Address:		
E-mail Address:	Home Phone:	Work Phone:

❑ Health Flexible Spending Account — Total Amount Requested: _____

Date of Service	**Employee, Spouse or Dependent**	**Amount Requested**	**Type of Service** (Rx, co-pay, dental expense, etc).	**Service Provider/Rx Number** (Must be provided)
1.				
2.				
3.				
4.				

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 pharmacy receipt, not the cash register receipt.

❑ Dependent Care Reimbursement Account — Total Amount Requested: _____

Dependent Care Provider Signature: _____ Date: __/__/__

PLEASE NOTE: *For all Dependent Care FSA claims, you must provide the business Tax ID Number, date(s) of service, name of child(ren) and services rendered. If you're using the account to pay for the cost of an individual/babysitter, you must provide the person's Social Security Number in the table below. If you cannot remit a copy of your bill/contract, your daycare provider must sign on the line above in lieu of submitting a receipt.*

Date(s) of Service	**Name of Dependent**	**Amount Requested**	**Type of Service** (i.e., day care center, after school program, adult day care)	**Service Provider/Number** (Must be provided)
1.				
2.				
3.				
4.				

PARTICIPANT SIGNATURE REQUIRED

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 I will not seek reimbursement for this through any other benefit plan. This expense will not be claimed as an income tax deduction. In addition, as to the dependent care expenses identified above (if any), I meet each of the certifications at "Qualifying Care Expense Certifications" on the next page. I certify that if my child is age 13, I will not seek reimbursement for more than the unspent funds from my prior year account. I authorize my Flexible Spending Account to be reduced by the amount requested.

Employee's Signature: _____ Date: __/__/__

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Claim Submission Requirements

- Please number each receipt according to the 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

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 step-sibling, 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 a 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 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.