

**P & A Administrative Services, Inc.
Flexible Spending Account Claim Form**

Today's Date: _____
of pages: _____

- NEW CLAIM
- DEBIT CARD DOCUMENTATION
- RESUBMISSION

This claim is for the plan year beginning July 1, 2008

Employer Name: TOWN OF CARY	<input type="checkbox"/> Please check if this is a new address
Employee Name:	Employee Mailing Address:
<u>Last 4 digits</u> of Social Security Number:	City, State, Zip:
E-mail Address:	Daytime Phone Number:

- Medical Expense Reimbursement Account Total Amount Requested _____
- Dependent Care Reimbursement Account Total Amount Requested _____

Date of Service	Employee, Spouse or Dependent	Amount Requested	Type of Service	Service Provider or RX #
1.				
2.				
3.				
4.				
5.				

1. 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.
2. Please number each item according to its order of appearance on this form.
3. IRS guidelines do **NOT** consider cancelled checks as valid documentation.
4. Previous balances are **NOT** acceptable.
5. Complete all information on claim form including signature and date.
6. All reimbursements will be made payable to the employee.

I certify that these expenses for which reimbursement is claimed from the Flexible Spending Accounts have been incurred by me and/or my eligible dependents and are not, and will not, be payable by any other plan and will not be deducted on my federal, state or local income tax returns. (Claim forms not signed will not be processed.)

EMPLOYEE'S SIGNATURE _____ DATE _____

**For faster service, fax claims to:
1-877-855-7105 (toll free)**

Or mail to: Flex Department, P&A Administrative Services, Inc., 17 Court Street, Suite 500, Buffalo, NY 14202-3204

Visit our website to access account information: www.padmin.com