



# Claim Form

## Fax to 951-656-9276

6 pages per claim max please  
Or you can email claims & Form to [claims@pagroup.us](mailto:claims@pagroup.us)

### Flexible Spending Account Claim Form Instructions

Please follow these instructions carefully—we receive many ‘mystery’ claims.

- Before faxing make sure your pages and cover sheet are placed in position with the proper side down or up, depending on your fax machine.
- Please write clearly. We cannot pay a claim that is not legible.
- Include clear copies of your itemized receipts.
- You can go online to see if we've received your claim (we enter all claims within 48 hours of receipt).
- To avoid delays please complete all requested information.

Please limit your fax to 6 pages, including the cover. Additional pages should have a new cover/claim form attached. We have found that on occasion faxes that are sent with more than 6 pages have a tendency to jam or not finish receiving.

\_\_\_\_\_ # of Pages total, including Claim  
Please limit to 6 pages

\_\_\_\_\_  
Your Name

\_\_\_\_\_  
Your Telephone Number or email address (where we can reach you if we have a question or need to contact you)

\_\_\_\_\_  
Your Employer Name

\_\_\_\_\_  
Employee ID

\_\_\_\_\_  
Date

#### Statement of Fact:

I am submitting a claim under my employer sponsored reimbursement plan. I understand that the expense must be incurred in the current plan year, or subsequent extension if plan design allows; I understand that itemized receipts will be reviewed and must be legible; I agree that I will not seek reimbursement under any other plan for this expense; and I agree that I cannot use this expense as a deduction when filing my taxes. I further understand that funds that remain in the plan after the plan year ends (and subsequent plan year grace period) will be forfeited. This is known as the “use it or lose it” rule.

#### Indicate amount claimed by category

\_\_\_\_\_  
Signature

\$ \_\_\_\_\_ Health Care FSA

\$ \_\_\_\_\_ Dependent Care FSA

\$ \_\_\_\_\_ Other \_\_\_\_\_

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