

**EMPOWER FSA CLAIM FORM**

Employer _____ Daytime Phone # _____
 Name _____ SSN (Last 4) # _____
 Email Address _____ Date of Birth (i.e.09/24/2004) _____

Dependent Care Expense Claims

Name of Dependent(s)	Period Covered	Name, Address, and Taxpayer Identification Number of Provider of Service	Amount Incurred
		*Total Dependent Care Expense Claim	

NOTE: No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or if your child or stepchild is under 19.

Unreimbursed Medical Expense Claims*PLEASE ATTACH RECEIPTS TO THIS FORM*

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
		Total Medical Care Expense Claim		

Read Carefully

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company’s Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee’s Signature _____

Date _____

Mail, fax or email this form to:

EMPOWER
 7309 E 21st St, Suite 110, WICHITA, KS 67206
PHONE: (316) 687-3444 (800) 819-9571 **FAX:** (316) 687-2113
EMAIL: CustomerService@Empowerflex.com
FOR BALANCE INFO: Visit www.EmpowerFlex.com

Claim Filing Instruction

Who Can File a Claim Form?

- ___ Only employees participating in the Cafeteria Plan can file a reimbursement claim form.
- ___ Employees can file a claim form during the Plan Year and for a certain period after the Plan Year as described in the Summary Plan Description.
- ___ Terminated employees can file a claim form for a certain period after the date of termination if allowed by the Plan. Please see your Summary Plan Description.

What Expenses can be claimed?

- ___ Only expenses incurred during the Plan Year can be claimed for reimbursement. Each year is treated separately and the year of the claim is the year the expense was actually incurred by the participant. It is imperative to send separate claim forms for each plan year.
- ___ Terminated employees can request reimbursement for expenses incurred during the time period for which contributions were received. Please see your Summary Plan Description.
- ___ Allowed expenses are the same as those allowed for tax purposes except for long-term care premiums and expenses. A summary list is provided here for your convenience.

Qualifying Dependent Day Care Expenses:

- Expenses, necessary for you and your spouse (if married) to be gainfully employed
- ___ Expenses paid to a dependent day care center or care provider.
 - ___ Expenses paid for the care of a dependent under age 13 that lives with you.
 - ___ Expenses paid for care of other dependents that live with you and are physically or mentally incapable of caring for themselves.

Qualifying Un-reimbursed Medical Expenses:

Ambulance hire	Elastic hose, medically prescribed	Hospital	Physical	Rental of medical or healing
Artificial limbs & Teeth	Eyeglasses/Contact lenses	Laboratory	Physiotherapist	equipment
Automobile	Fees:	Lip reading	Podiatrist	Seeing-eye dog
Modifications (hand	Acupuncture	lessons for	Practical Nurse	Special Education
Controls, special	Anesthetist	the deaf	Psychiatrist	Support or corrective
Equipment, mechanical	Blood donor	Medical info-	Psychoanalyst	devices (including
Lifts)	Chiropodist	plan	Psychologist	special mattress and
Braille book	Chiropractor	Midwife	Specialist	board for arthritis)
Magazines	Clinic	Nurse	Surgeon	Telephone for deaf
Contact lens solution	Dentist	Obstetrician	Hearing devices	Television set modifications
Co-pays	Diagnosis	Oculist	Hospital bills	to receive closed captions
Crutches	Diathermy	Ophthalmologist	Nursing Care	Therapy treatments
Deductibles	Exam, physical	Optician	Obstetrical	Travel expense due to illness
Drugs	Eye exams	Optometrist	Operations &	Wheelchair
(OTCs, prescriptions,	Feminine Products	Oral surgery	related treatments	X-rays
insulin & medical		Orthodontia		
supplies)		Pediatrician		

Completion of the Claim Form

- ___ Complete all information on the claim form for each amount claimed for reimbursement.
- ___ Make sure the claim does not include items for more than one Plan Year. Use different claim forms for different years.
- ___ You **MUST** sign and date the claim form.
- ___ Attach a copy of a bill, invoice, or other written statement from a third party which supports each reimbursement request and shows the date the service was incurred.
- ___ Copies of cancelled checks or credit card receipts are not valid receipts.

How to Request Changes in Plan Participation

- ___ Revocation of participation in the Plan can only occur if you have a change in status. Change in family status includes birth, death, marriage, divorce, change of employment by the spouse, change in work schedule, and change in dependent eligibility, change in residence or worksite, or certain other situations as determined by the Plan Administrator.