EMPOWER FSA CLAIM FORM

Employer _____ Daytime Phone #_____
Name _____ Social Security #_____
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: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, and $400 if there are two (2) or more.) 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 age 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 reimburseable 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 N Ste 110 WICHITA, KS 67206-1178
PHONE: (316) 687-3444 (800) 819-9571 **FAX:** (316) 687-2113
EMAIL: CustomerService@EmpowerFlex.com
FOR BALANCE INFO: Visit www.myflexonline.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
Artificial limbs & Teeth
Automobile Modifications (hand Controls, special Equipment, mechanical Lifts)
Braille book Magazines
Contact lens solution
Co-pays
Crutches
Deductibles
Drugs (legal – prescription and *over the counter
Insulin and medical Supplies
Elastic hose, medically prescribed
Eyeglasses/Contact lenses
Fees: Acupuncture, Anesthetist, Blood donor, Chiropodist, Chiropractor
Clinic
Dentist
Diagnosis
Diathermy
Exam, physical
Eye exams
Gynecologist
Hospital Laboratory
Lip reading lessons for the deaf
Medical info-plan
Midwife
Nurse
Obstetrician
Oculist
Ophthalmologist
Optician
Optometrist
Oral surgery
Orthodontia
Pediatrician
Physical Physiotherapist
Podiatrist
Practical Nurse
Psychiatrist
Psychoanalyst
Psychologist
Specialist
Surgeon
Hearing devices
Hospital bills
Nursing Care
Obstetrical
Operations & related treatments
Rental of medical or healing equipment
Seeing-eye dog
Special Education
Support or corrective devices (including special mattress and board for arthritis)
Telephone for deaf
Television set modifications to receive closed captions
Therapy treatments
Travel expense due to illness
Wheelchair
X-rays

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, change in dependent eligibility, change in residence or worksite, or certain other situations as determined by the Plan Administrator.