



**EMPOWER FSA PLAN AND HRA
PARTICIPANT TERMINATION FORM**

COMPANY NAME:	
EMPLOYEE NAME:	EMPLOYEE SS#:
LAST DAY WORKED:	COVERAGE TERMINATION DATE:
	Total of contributions made up to term date:
AUTHORIZED SIGNATURE:	TODAY'S DATE:

Please return form to EMPOWER by mail, fax or email:

**Mail: Empower
7309 E. 21st Street North, Ste 110
Wichita, KS 67228**

Fax: 316-687-2113

Email: CustomerService@EmpowerFlex.com