HRA Claim Form

Health Reimbursement Arrangement

Employer: _____

Employee Name: _____ Last 4 of SSN: _____

Daytime Phone: _____ Email: _____

Health Reimbursement Arrangement Expense Claims			
Date Expense Incurred	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form		**Total Health Reimbursement Arrangement Expense Claim**	**$**

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the medical expenses have not and will not be reimbursed 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.

! *Your Health Reimbursement Arrangement Plan (HRA) Plan may be limited by the type of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan for a list of eligible expenses.*

Employee Signature: _____ Date: _____

Mail To:
EMPOWER
7309 # 21st St N Suite 110
Wichita, KS 67206

Fax To:
(316) 687-2113

Email To:
customerservice@empowerflex.com