EMPOWER HSA CLAIM FORM

Employer Name _____ Daytime Phone # _____
Email Address _____ Social Security # _____
Date of Birth (i.e.09/24/2004)_ _____

FSA - Dependent Care Expenses

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.

HSA - Medical Expenses

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 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

Qualifying Dependent Day Care Expenses (for Consumers enrolled in FSA Dependent Care ONLY:

Depenent Care receipts must be included with this Claim Form.

Qualified Dependent Care expenses are Dependent Care 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.

Examples of HSA Qualifying Unreimbursed 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 (prescriptions, insulin & medical supplies)
Elastic hose, medically prescribed
Eyeglasses/Contact lenses
Fees: Acupuncture Anesthetist Blood donor Chiropodist Chiropractor
Feminine products
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
OTCs
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

Completing the Claim Form

__Complete all information on the claim form for each amount claimed for reimbursement.

__You **MUST** sign and date the claim form.

__Receipts must be included as support for Dependent Care claims amounts.

__Although you are not required to submit copies of HSA Medical receipts along with this Claim Form, please keep these receipts in case they are required for a future tax audit.