POWERGROUP ADMINISTRATORS

Employee Benefit Claim Form

1. Please provide all requested information for each claim and sign the form. **2.** Attach an **itemized statement** for each of your expenses which include the date and type of service. Canceled checks, credit card slips, or balance due statements are **NOT** allowed. **3.** Keep your original claim form and supporting documents for your records. **4.** When faxing claims do not follow-up with a hard copy via mail.

Part I: Employee Participant Information (Please Print)

Employee Participant Name:		Company Plan Sponsor Name:	
Street Address:	City:	State:	Zip:
Phone:	Email Address:	SSN:	
Check **ONE**: ☐ New Claim ☐ Resubmitted Claim ☐ Debit Card Substantiation			

Part II: Medical Flexible Spending Account Reimbursement

List the expense which you are requesting reimbursement for. Please read your Summary Plan Description for a list of your eligible expenses.

Date of Service	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Reimbursement Amt Requested
🗁 Please attach all appropriate receipts and submit with this claim form.		**Total Reimbursement Requested:**		

Part III: Dependent Care Expenses (Child or elder care expenses)

If your employer sponsors and you participate in a Dependent Care Plan, please read your Summary Plan Description for a list of your eligible expenses.

Name of Dependent(s)	Dep(s) Age	Dates of Service		Day Care Provider Information			Reimbursement Amt Requested
		From	To	Name	Address	Tax ID	
🗁 Please attach all appropriate receipts and submit with this claim form, **or** include Provider's signature in the space below.				**Total Reimbursement Requested:**			
				✍ **Day Care Provider's Signature:**			

Part IV: Employee Certification

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 Employer sponsored 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 re-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 (Required): _____ **Date:** _____

How to Submit your FSA Health Care Claim

To Complete a Health Care reimbursement request (a claim), you must submit a Health Care Claim Form along with the receipts that clearly show an eligible expense was incurred. Here are the steps to follow:

1. Complete a Health Care Claim Form
2. Attach itemized documentation and. if required, your physician's statement of necessity
3. Fax the form and documentation to 1-866-578-1673
4. You may also email your claim to PGAClaimsFaxes@pgcompanies.com

The Claim Form must be completed entirely, dated and signed. The supporting receipts or billing statements must state the vendor's name, vendor contact information, purchase date, a description of the expense(s) and the expense amount. An Explanation of Benefits (EOB) from the medical plans can also be used as supporting documentation for your claim. **A Credit Card receipt or canceled check is not adequate documentation**. Credit card receipts do not list the individual items purchased along with a description of the item. This is why you must save your purchase receipts, bills, itemized statements or EOB. Heath Care claims cannot be processed for payment without proper supporting documentation.

You may submit up to 9 purchases on a single Health Care Claim Form, using a separate line for each purchase. Please fax (fastest process) or mail the documents (keep a copy) but please do not do both. Place the documents in this order: Health Care Claim Form first, then the supporting documentation. Please do not return the instruction page and no cover sheet is required.

Fax: (Toll Free)1-866-578-1673 (Local) 913-491-6379
Email: PGAClaimsFaxes@pgcompanies.com
Mail to: Power Group Company
P.O. Box 11290 Overland Park, KS 66207

Good Receipt

RX Pharmacy 1-25-2010
(999) 999-9999

Customer: John Doe

Vigamox 0.5 % Eye Drops
Instill one drop 4 times per day

Amount $22.54
Rx Pharmacy, Inc. 123 Anywhere Anywhere CT 99999

Receipt Missing Information

123 Eye Associated
123 City Street
Somewhere, CT 99999

Date 1-26-2010 Time: 07:25 a.m.
Item: 0034 VIS Sale
ACCT: xxxxxxxxxxx30
Auth: 999
TOTAL $45.00
I agree to pay above amount
According to card issuer agreement
(Merchant Agreement if Credit Voucher)
X_____

Why Providing Documentation is Important

The IRS has provided strict requirements stating that expenses reimbursed through a Flexible Spending Account must be substantiated using itemized receipts, statements or explanation of Benefits. All supporting documentation must reflect the vendors name, vendor contact information, purchase/expense incurred date, a description of the expense(s) and the expense amount(s). Health Care Claims submitted without eligible documentation cannot be approved for payment or debit card transaction substantiation, per IRS regulations. If your claim is declined for improper documentation, or if the expense is deemed ineligible, you will be notified by Power Group via U.S. Mail Service.