Powell Industries HRA Claim Form

______________________________________ _______________________________

Participant Last Name/First Name – please print **Social Security Number**

To request reimbursement for the following expenses under your employer's Plan, please include an Explanation of Benefits (EOB) from your employer-sponsored insurance plan or itemized prescription receipt showing the expense type, date of service, provider name and your cost along with this claim form. If you need additional space, please attach another page with the remainder of your itemized expenses.

The Consumer Driven Health Plans require participants meet a deductible before expenses are paid from the plan. You can use your HRA funds for medical expenses to help meet your deductible. You can also use HRA funds to pay prescription drug copays which do not apply toward your deductible, but do apply toward your out-of-pocket maximum.

Health Care Expenses: $_________

I further testify that I have attached records necessary to substantiate these expenses. I understand that since these expenses are reimbursed through my reimbursement account, they may not be claimed as a federal income tax deduction or credit at year end. I further certify that I will not submit these expenses for payment by a third party, such as my major medical plan, or any other health plan, such as an individual policy or my spouse's or dependents' health plan.

___________________ __________

Participant Signature **Date**

Submit Claim To: **TaxSaver Plan**

P.O. Box 609002

Dallas, Texas 75360

Fax: 214-528-8122

claims@taxsaverplan.com attach jpg, tiff, pdf, or jif files. **www.taxsaverplan.com**

Contact Us: **800-328-4337** **csr@taxsaverplan.com www.taxsaverplan.com**