Flexible Spending Accounts Reimbursement Request

For faster service, log into your account at www.tri-ad.com to file your claim electronically and upload your receipts!

NOTE: This is a two-page form with important information on Page 2. Page 2 may be printed on the reverse of this form. Please do not sign this form before reviewing the information on Page 2.

your contact information ☐ check here if this is a new address		
Last Name:	First Name:	Last 4 digits of SSN or EEID:
Street Address:		Email:
City:	State:	Zip:
Employer Name:		

dependent day care expenses See Page 2 for additional information. Use the Provider Certification section only if no receipt is attached.

Date(s) Services Incurred	Provider Name and Address	Dependent Name	Age	Amount Requested
to				
to				
to				
to				
		dependent day care expenses total:		

Note: A receipt is not required if your provider signs below.

Provider Certification Verification:

I certify that the Dependent Day Care expenses listed above were incurred by the participant named above.

Provider's Signature: ……………………………………………………… Date: ______________________

health care expenses Attach documentation and receipts from the provider containing all five (5) information requirements detailed on Page 2.

Note: Any ineligible *BenefitCard* transactions will be offset with this claim, if applicable. See Page 2 for additional information.

(1) **Dates of Service**	(2) **Service Provider Name** (Physician, Hospital, Dentist, Pharmacy, etc.)	(3) **Description of Service** (Co-pay, Deductible, Dental, Vision, Over the Counter, Rx, etc.)	(4) **Expense Incurred for Whom and Relationship**	(5) **Amount Requested**
			health care expenses total:	

I have read all the terms and conditions on Page 2 of this form and agree to comply by the terms of my employer's Plan. I certify that the above expenses meet the requirements for eligibility under the Plan, as described in the Plan documents and the information on Page 2 of this form.

Participating Employee's Signature: ______________________________ Date: ______________________

File Online: www.tri-ad.com
One-time registration required.
Forms cannot be accepted via email.

Fax to: Tri-Ad
Toll Free Fax: 844-791-8318

Mail to: Tri-Ad
221 West Crest Street, Suite 300
Escondido, California 92025

Contact TRI-AD Participant Services Monday – Friday from 5:00 a.m. to 6:00 p.m. Pacific Time, at 888-844-1372 or flexmail@tri-ad.com. NOTE: Forms cannot be accepted via email.

Social Security Number / Other Employee ID Number

Use your Social Security Number unless you were notified of an alternate I.D. number (e.g., EEID, etc.)

Dependent Care Claims

Dependent Care Expense Documentation/Substantiation Instructions

- **If you have more claims than will fit on the form**, please complete an additional claim form or sheet of paper.
- documentation must show the service provider's name, the service date, service description, the person for whom the service is rendered (name, age and relationship) and the amount. Valid documentation would be an itemized invoice from the service provider. *Canceled checks, credit card receipts, or balance due statements are not acceptable.* **Retain the original documents for your records.** You may, at some point, need original receipts/documents for an IRS audit. TRI-AD needs copies of your documentation only.

Dependent Care Expense Disclaimer

I certify that, to the best of my knowledge, all reimbursements requested hereon are accurate. I also certify that:

- The expenses have been incurred during the Plan year, as defined by the Plan. Expenses are incurred on the date services are provided, not the date you are billed or when payment is made.
- These expenses were incurred for an eligible dependent, as defined by the Plan.
- These expenses are out-of-pocket expenses that qualify as valid Dependent Care Expenses under the Plan.
- These expenses have not been reimbursed through any other plan or through any other method or means, nor will I seek reimbursement elsewhere.
- These expenses may not be used to claim any federal income tax deduction or credit (such as the Dependent Care Credit). I agree to complete and file IRS Form 2441 with my tax return and provide any Taxpayer Identification Number required thereon.
- The amount of reimbursement requested, added to the amount received year-to-date, does not exceed the statutory limits described in the Summary Plan Description.

Health Care Claims

Health Care Expense Documentation/Substantiation Instructions

- **If you have more claims than will fit on the form,** please complete an additional claim form or sheet of paper.
- **Health care services:** Documentation must show the service provider's name, the service date, service description, the person for whom the service is rendered (name and relationship) and the amount. Valid documentation would be an itemized invoice from the service provider or Explanation of Benefits from the insurance company. *Medical or dental insurance claim forms, canceled checks, credit card receipts or balance due statements are not acceptable.*
- **Prescription drugs:** Prescription receipts must show date, doctor, name of patient and type of medication. Either the "bag tags" from the prescription and/or a dated cash register receipt showing "Prescription" or "Rx" on the print-out (i.e., not hand-written or after-the-fact) is acceptable. *Canceled checks, credit card receipts and cash register receipts showing just the amount are not acceptable.*
- **Over-the-counter items:**
  - Over-the-counter drugs/medicines: Effective January 1, 2011, you must obtain a prescription from your physician in order to be reimbursed for over-the-counter drugs/medicines. You may have a pharmacy fill the prescription and provide TRI-AD with a receipt that shows the name of the person for whom it is for, date, amount of the purchase and the Rx number.
  - Over-the-counter items other than drugs or medicines: Dated cash register receipts with a description of the item (e.g., "Band-Aids") pre-printed on the receipt are acceptable.

  Canceled checks, credit card receipts and cash register receipts showing just the amount or a description too general to tie the claim to the expense are not acceptable. **Retain the original documents for your records.** You may, at some point, need original receipts/documents for an IRS audit. TRI-AD needs copies of your documentation only.

Health Care Expense Disclaimer

I certify that, to the best of my knowledge, that all reimbursements requested hereon are accurate. I also certify that:

- The expenses have been incurred during the Plan Year, as defined by the Plan. Expenses are incurred on the date services or treatments are provided not the date billed or when payment is made.
- These expenses were incurred either by me or an eligible dependent, as defined by the Plan.
- These expenses have not been reimbursed through any other plan covering health benefits or through any other method or means, nor will I seek reimbursement elsewhere.
- Any medical expenses for medical care or medication are not for cosmetic purposes.
- Any over-the-counter items claimed are for treating a specific medical condition, and not for general health maintenance or cosmetic purposes. Toiletries are not eligible. I must have a prescription for over-the-counter drugs/medicines prior to purchasing these items.
- I will not seek a tax deduction for amounts for which reimbursement is made.
- Any drugs purchased outside of the United States are legal in the United States and were only consumed in the country in which they were purchased.

I understand that I alone am fully responsible for the sufficiency, accuracy, and veracity of all information relating to claims submitted which I provide for myself and my qualifying child(ren) or qualifying relative(s), as defined by The Working Families Tax Relief Act, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

Offsetting Ineligible BenefitCard Expenses

We will use your attached receipts of eligible expenses to clear ineligible *BenefitCard* transactions. Any remaining balance of this claim will be reimbursed to you via a check mailed to your home or, if applicable, a direct deposit to your account.