



Dependent Care Flexible Spending Accounts Provider Certification

Log into your account at www.tri-ad.com to upload this form and attach it to your Dependent Care FSA claim.

YOUR CONTACT INFORMATION		
Last Name:	First Name:	Last 4 digits of SSN or EEID:
Street Address:		Email:
City:	State:	Zip:
Employer name:		

DEPENDENT DAY CARE EXPENSES				
Date(s) Services Incurred	Provider Name and Address	Dependent Name	Age	Amount Requested
to				
to				
to				
to				
DEPENDENT DAY CARE EXPENSES TOTAL:				

If your Day Care Provider signs below, this form substantiates your Dependent Care FSA claim for reimbursement and no receipt is needed.

Provider Certification Verification: I certify that the Dependent Day Care expenses listed above were incurred by the participant named above.	
Provider's Signature: _____	Date: _____

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. I also understand 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 that relate to such expense.	
Participating Employee's Signature: _____	Date: _____

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

Mail to: TRI-AD
221 West Crest Street, Suite 300
Escondido, California 92025

Fax to: TRI-AD
Toll-Free Fax: 844-791-8318

Get Reimbursed Faster!

Log into your account at www.tri-ad.com and sign up for direct deposit.

Have questions?

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.