

TAI**Flexible Benefit Plan - Claim Form****ONLINE***All Information Required - Print Clearly - Sign & Date Below*▶ **EMPLOYER** _____

Employee _____ Social Security # _____

Home Address (Street) _____ Check box if: New Address

City _____ State _____ Zip code _____

Daytime Phone (____) _____ Check box if Date Terminated: _____

E-Mail Address _____

- ▶ **HOW TO FILE A CLAIM:** (1) Complete Form listing expenses. Attach extra Forms if needed. SIGN and DATE below. (2) Attach copies of receipts and retain a set for your records. (3) Mail to Trust Administrators, P.O. Box 20710, Oakland, CA 94620 [Be sure your postage is correct]
 Questions? (800) 932-3539 www.trustadmin.com
FAX CLAIM: 1-510-451-8611 • BE SURE YOUR DOCUMENTATION IS LEGIBLE.

Health Care Reimbursement Account

NAME OF PERSON RECEIVING BENEFIT	DATE SERVICE INCURRED	DESCRIBE EXPENSE (MEDICAL, DENTAL, VISION)	AMOUNT CLAIMED
TOTAL			\$

Dependent Care Reimbursement Account

Provider's Tax I.D. or SS# _____ Provider's signature serves as your receipt.

Name of Provider _____ Provider's Signature _____

NAME OF DEPENDENT RECEIVING BENEFIT	DATE SERVICE INCURRED	DESCRIBE EXPENSE (CHILD OR OTHER DEPENDENT)	AMOUNT CLAIMED
TOTAL			\$

For dependent care, if your expenses are the same each month, submit a claim for the entire plan year (along with the provider information) and you will never miss a reimbursement cycle. Submit new form if provider changes.

▶ Employee Signature _____ Date _____

I understand the expenses claimed above will not be claimed from another Plan or taken as deductions or tax credits on my tax return.