TAI

ONLINE

Flexible Benefit Plan - Claim Form

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 Terminated: ☐ Date Terminated: ____________

E-Mail Address ____________________

▶ HOW TO FILE A CLAIM:
Questions? (800) 932-3539
www.trustadmin.com

(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]
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

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.

TOTAL $

▶ 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.