

**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
<b>TOTAL</b>			<b>\$</b>

**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
<b>TOTAL</b>			<b>\$</b>

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.