Health Savings Account (HSA) Claim Form

Reimbursement to Employee

1. Employer

2. Employee Name

☐ Check box if new address

Social Security Number

Home Street Address

City State Zip code

Daytime ( ) Email Address

Check box if employment ☐ Date of termination:

▶ **HOW TO FILE A CLAIM:**

(1) Complete Form listing expenses for spouse or dependents either enrolled or not enrolled in your HSA Plan. If individuals are not enrolled in your HSA Plan, but enrolled in another health plan, expenses related to accident, disability, dental, vision, or long-term care insurance are tax-free. Other expenses such as drug or office visit copayments may not qualify for tax-free treatment, but will be reimbursed to you. You are obligated to report any nonqualified reimbursement to the IRS. Review your Employee Summary for additional information. Attach extra Claim Forms if needed. SIGN and DATE below.

(2) Attach copies of receipts or other documents such as EOBs from insurance carriers. Keep all original documents for your records.

(3) Fax or Mail to Trust Administrators, Inc., P.O. Box 20710, Oakland, CA 94620 [Be sure your postage is correct]

▶ **FAX CLAIM TO: 1-510-451-8611** • DOCUMENTS MUST BE LEGIBLE.

Name	Date of Service	Indentify (Self, Child, Spouse)	Enrolled In Your HDHP? Yes/No	Describe Expense (Medical Check-up, Dental, Vision)	Amount Claimed

Advise TAI of changes in your HSA regarding the addition or deletion of dependents, deductibles, etc. Change Forms are available from TAI's website or your HR Dept.

TOTAL $

3. Account Holder Authorization

▶

Signature of Account Holder **Date**

Account Holder acknowledges responsibility under this HSA for payment to service providers.
In addition, expenses claimed will not be sought from another Plan or taken as deductions on my tax return.

www.trustadmin.com • 800-932-3539 • Fax: 510-451-8611