

Flexible Spending Accounts Reimbursement Request

Note: This is a two-page form with important information on Page 2. Page 2 may be printed on the reverse of this form. Please do not sign this form before reviewing the information on Page 2.

IF FAXING:
No. Pages: _____

YOUR CONTACT INFORMATION CHECK HERE if this is a new address

Last Name: _____ First Name: _____ SSN: _____

Address: _____

City: _____ State: _____ ZIP: _____

DEPENDENT DAY CARE EXPENSES – See reverse for instructions

| Date(s) Services Incurred | Service Provider Name | Name and Age of Person for whom Service Was Rendered | Amount |
|--|-----------------------|--|--------|
| to | | | |
| to | | | |
| GRAND TOTAL OF DEPENDENT DAY CARE EXPENSES: | | | |

Day/Child Care Provider Number or Social Security Number: _____

(Day Care Provider's Signature is required if not providing a signed, paid receipt.) I certify that the information provided in the Dependent Day Care Expenses section above is correct.

Provider's signature _____ Date: / /

HEALTH CARE EXPENSES – Attach documentation and receipts. See reverse for instructions.

Medical Services and Prescription Drugs

| Date(s) Services Incurred | Service Provider Name | Description of Expense | Expense Incurred for Whom & Relationship | Amount |
|---|-----------------------|------------------------|--|--------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Medical Services and Prescription Drugs Total: | | | | |

Over-the-Counter Drugs, Medicines, & Health Supplies

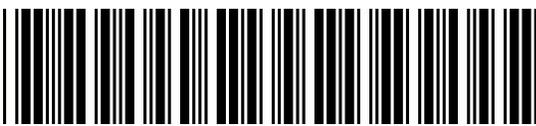
| Date(s) Services Incurred | Product Name | Health Condition Being Treated | Expense Incurred for Whom & Relationship | Amount |
|--|--------------|--------------------------------|--|--------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Over-the-Counter Drugs, Medicines, & Health Supplies Total: | | | | |

I have read all the terms and conditions on Page 2 of this form and agree to comply by the terms of this Plan. I certify that the above expenses meet the requirements for eligibility under the Plan, as described in the Plan documents and the information Page 2 of this Form.

Participating Employee's Signature _____ Date / /

Fax or Mail to:
TRI-AD
221 West Crest Street, Suite 300
Escondido, CA 92025

Fax: 760-233-4741
Toll-Free Fax: 866-233-4741
Phone: 888-844-1FSA (1372)



CITY OF RIVERSIDE 182

Dependent Care Claims

Dependent Care Expense Documentation/Substantiation Instructions

- **If you have more claims than will fit on the form**, please complete an additional claim form.
- Documentation must show the service provider's name, the service date, service description, the person for whom the service is rendered (name, age, and relationship), and the amount. Valid documentation would be an itemized invoice from the service provider. *Canceled checks, credit card receipts, or balance due statements are not acceptable.* **Retain the original documents for your records.** You may, at some point, need original receipts/documents for an IRS audit. TRI-AD needs copies of your documentation only.

Dependent Care Expense Disclaimer

I certify that to the best of my knowledge, all reimbursements requested hereon are accurate. I also certify:

- The expenses have been incurred during the Plan Year, as defined by the Plan. Expenses are incurred on the date services are provided not the date you are billed or when payment is made.
- These expenses were incurred for an eligible dependent, as defined by the Plan.
- These expenses are out-of-pocket expenses that qualify as valid Dependent Care Expenses under the Plan.
- These expenses have not been reimbursed through any other plan or through any other method or means, nor will I seek reimbursement elsewhere.
- These expenses may not be used to claim any federal income tax deduction or credit (such as the Dependent Care Credit). I agree to complete and file IRS Form 2441 with my tax return and provide any Taxpayer Identification Number required thereon.
- The amount of reimbursement requested, added to the amount received year-to-date, does not exceed the statutory limits described in the Summary Plan Description.

Health Care Claims

Health Care Expense Documentation/Substantiation Instructions

- **If you have more claims than will fit on the form**, please complete an additional claim form.
- **Health care services:** Documentation for health care services must show the service provider's name, the date of service, a description of the service, the person for whom the service is rendered, and the amount. Valid documentation would be an itemized invoice from the service provider or Explanation of Benefits from the insurance company. *Canceled checks, credit card receipts, or balance due statements are not acceptable.*
- **Prescription drugs:** Prescription receipts must show date, doctor, name of patient, and type of medication. Either the "bag tags" from the prescription and/or a dated cash register receipt showing "Prescription" or "Rx" on the print-out (i.e., not hand-written on after-the-fact) is acceptable. *Canceled checks, credit card receipts, and cash register receipts showing just the amount are not acceptable.*
- **Over-the-counter items:** Dated cash register receipts with a description of the item (e.g., "Benadryl", "Tums") pre-printed on the receipt are acceptable. *Canceled checks, credit card receipts, and cash register receipts showing just the amount or a description too general to tie the claim to the expense are not acceptable.* **Retain the original documents for your records.** You may, at some point, need original receipts/documents for an IRS audit. TRI-AD needs copies of your documentation only.

Health Care Expense Disclaimer

I certify that to the best of my knowledge, all reimbursements requested hereon are accurate. I also certify:

- The expenses have been incurred during the Plan Year, as defined by the Plan. Expenses are incurred on the date services or treatment are provided not the date you are billed or when payment is made.
- These expenses were incurred either by me or an eligible dependent, as defined by the Plan.
- These expenses have not been reimbursed through any other plan covering health benefits or through any other method or means, nor will I seek reimbursement elsewhere.
- Any medical expenses for medical care or medication are not for cosmetic purposes.
- Any over-the-counter items claimed are for treating a specific medical condition, and not for general health maintenance or cosmetic purposes. Toiletries are not eligible.
- I will not seek a tax deduction for amounts for which reimbursement is made.

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 eligible dependents, and 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 which relate to such expense.