DEBIT CARD EXPENSE SUBSTANTIATION FORM

Employee Information: Complete all sections.				
Employer Information	Name of Your Employer			
Employee Information	Employee's Last Name	First Name	Initial	Employees Social Security Number / /
	Home Address			
Check box if new address. ☐	City	State	Zip	Employee e-mail address

Debit Card Expense: An itemized statement is required including date of service, type of service, and total charge.					
Claim No.	Plan Name	Date of Service	Provider/Merchant	Recipient Name	Claim Amount

Employee Certification: Employee signature required.	
I certify that the above information is correct. I understand any medical reimbursements I receive may not be included on my income tax return. I certify that I am sending in receipts for the purchases in which I used with my debit card. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code.	
Employee's Signature	**Date** / / **Mo. Day Year**

Please send the completed form and copies of receipts itemizing a Debit Card purchase(s) to:

TRISTAR Benefit Administrators

P.O. Box 65887
West Des Moines, IA 50265

Fax: 515-453-2354
or
Email: flex@tristargroup.net

TRISTAR℠
BENEFIT ADMINISTRATORS