Proof of Healthy Action Form

For faster service, log into your account at www.tri-ad.com to file your claim electronically and upload your receipts!

YOUR CONTACT INFORMATION		
Last Name:	First Name:	Last 4 digits of SSN or EEID:
Street Address:		Email:
City:	State:	Zip:
Employer Name:		

(1) Dates of Activity, Service or Purchase	(2) Service Provider or Merchant Name (Physician, Hospital, Dentist, Pharmacy, etc.)	(3) Description of Activity, Service or Purchase (Co-pay, Deductible, Dental, Vision, Over the Counter, Rx, etc.)

I have read all the terms and conditions as outlined in the Plan Summaries and agree to comply by the terms of my employer's Plan. I certify that the above expenses meet the requirements for eligibility under the Plan, as described in the Plan Summaries.

Participating Employee's Signature: _____	Date: _____

File Online: www.tri-ad.com
One-time registration required.
Forms cannot be accepted via email.

Fax to: TRI-AD
Toll Free Fax: 866-233-4741

Mail to: TRI-AD
221 West Crest Street, Suite 300
Escondido, California 92025

Contact TRI-AD Participant Services Monday – Friday from 5:00 a.m. to 6:00 p.m. Pacific Time, at 888-844-1372 or flexmail@tri-ad.com. NOTE: Forms cannot be accepted via email.