

## **TRI-AD FlexCard<sup>sm</sup> – Dependent Card Authorization**

**Instructions:** Please print clearly. Complete this form in its entirety and return it to TRI-AD either by fax or mail as noted below.

### **EMPLOYEE INFORMATION:**

Employer Name:

SDSU Research Foundation

Division:

Last Name:

First Name:

SSN#:

Address:

Phone: (     )

City:

State:

Zip:

Email:

### **DEPENDENT INFORMATION:**

Dependent's Last Name:

Dependent's First Name:

Dependent SSN#:

Relationship to Employee:

### **Authorization—Read Carefully**

I authorize TRI-AD to issue a *FlexCard<sup>sm</sup>* to my eligible dependent as listed above. I understand that I alone am responsible for my FSA account and the use of the *FlexCard<sup>sm</sup>* by my dependent. I understand that I am responsible for the sufficiency, accuracy, and veracity of all information relating to all claims and *FlexCard<sup>sm</sup>* transactions 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. I understand that no tax deduction is permitted for amounts for which reimbursement is made. I agree to comply by the terms of this Plan.

I understand that if I or my dependent use the TRI-AD *FlexCard<sup>sm</sup>* for purchases other than Qualified Expenditures or fail to provide proper documentation for my/our purchases, as determined by the Plan Administrator, the IRS or any other party having authority, that I have violated this Agreement and my obligations under my employer's Plan. I authorize my employer to collect from me personally or withhold such funds from my pay or any other amounts due including any taxes, fines, surcharges or penalties that may be assessed for the use of the *FlexCard<sup>sm</sup>* for Non Qualified Expenditures. I also understand that my Card and my dependent's card may be immediately suspended and/or permanently revoked.

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**Signature of Employee**

**Date**

**Fax or Mail to:**

**TRI-AD FSA Department  
221 West Crest Street, Suite 300  
Escondido, CA 92025**

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