PS Administrators
1600 Riviera Ave. #150
Walnut Creek, CA 94596
877.739.1574

Expense Reimbursement Request

Employer Name _____ Participant Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Last four of SSN _____ ☐ Check if name/ address change

Date(s) of Service	Name of Provider (Ex.: "ABC Pharmacy")	Description of Expense (Ex: "prescription")	Reimbursement Request Amount
		Total Amount	

Itemized receipts must be submitted with this form via:

Mail: Benefits Support Center, Payroll Systems, 1600 Riviera Ave, Suite 150, Walnut Creek, CA 94596
Fax: 925.464.7553
Online: Benefits Support Center - www.payroll-us.com/logins

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the employer's Plan with respect to such expenses, and that the expenses have not been reimbursed and are not reimbursable from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. The undersigned understands the submission of a fraudulent claim is a criminal act and may result in termination and the possibility of criminal charges. All payment of claims is from the employer's general assets.

Participant Signature _____ Date _____
MM/DD/YYYY