



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

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) 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

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 under-signed 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.

Instruction - Complete the following in its entirety _____

I, _____, am covered under the following health coverage: _____,
 The coverage continues to be minimum essential coverage (MEC). The submitted medical expense has not been previously reim-
 bursed and reimbursement will not be sought for the expense from any other arrangement or health plan.

Instruction - Also, complete the following if a family member's expense is being reimbursed from the QSEHRA.

The following family member _____, is covered under the following health coverage:
 _____.

The coverage continues to be MEC. The submitted medical expense has not been previously reimbursed and reimbursement will
 not be sought for the expense from any other arrangement or health plan.

I hereby affirm that the above information is true and accurate.

Signed: _____ **Date:** _____