San Francisco HRA
REIMBURSEMENT REQUEST FORM

Employer	Daytime Phone#	Secondary Phone#
Employee's Last Name	First Name	Employee's SS#
Employee's Mailing Address (Street)	City	State, Zip
Expenses Incurred By:	Relationship to Employee:	

____ CHECK HERE IF NEW MAILING ADDRESS

ITEMS REQUIRED TO SUBMIT THIS FORM:
(1) Complete all pertinent information in the spaces provided, sign, date & return to Administrative Solutions, Inc..
(2) Attach an itemized statement or receipt to support requested reimbursement(s).
(3) Statement/Receipt MUST have date of expense, expense description and amount of expense clearly listed for approval.

DATE OF EXPENSE	EXPENSE TYPE	REQUESTED AMOUNT

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 Plan with respect to such expenses; and that such expenses have not been reimbursed, or are not reimbursable, under any other benefit plan coverage. The undersigned fully understands that he or she alone is 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 the payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

_____ _____
Signature Date

ADMINISTRATIVE SOLUTIONS, INC.
P.O. Box 5809, Fresno, CA 93755-5809
Ph. (559) 256-1320 / Toll Free (866)777-1320 / Fax (559) 475-5789
SFClaims@asibenefits.com

To be completed by ASI	Date Claim Received:	Approved:	Denied:	Date Posted:	Posted By: