Benefit Administrators of California

HEALTH CARE RELATED EXPENSES REIMBURSMENT FORM

1. Employee Identification Information:

Name (First, Middle, Last): _____

Social Security Number (last 4 digits): _____

Birth Date: _____

Home Address: _____

Telephone (Home/Cell): _____

2. Health Care Related Expenses*

Expense Date	Person Name	Relationship to Employee	Expense Description (Purpose)	Expense Amount
				$
				$
				$
				$
				$
				$
				$

TOTAL: $

(*) Please print this form, complete relevant information and attach applicable supporting documentation and/or receipts. Please indicate if you would like the payment to be made directly to Healthcare Provider.

This form and supporting documentation maybe submitted in person, mailed to: Benefit Administrators of California, 5205 Prospect Rd, Suite 135-240, San Jose, California 95129, emailed to: help@baoca.net, or faxed to: (415) 675-5563. You should expect reimbursement within 30 days after submitting this form and appropriate supporting documentation.

We may verify submitted expenses by contacting appropriate service provider and shall not be required to reimburse employee for fraudulent expense submissions, expenses submitted without supporting documentation and expenses not qualified as health care expenses according to San Francisco Health Care Security Ordinance.

Additional information about San Francisco Health Care Security Ordinance can be found at the City and County of San Francisco Office of Labor Standards Enforcement website: https://sfgov.org/olse/health-care-security-ordinance-hcso