VENICE CHRISTIAN SCHOOL QSEHRA
Documentation of Medical Coverage

Instructions: Please complete all areas below and sign, date and return this form. In order to receive reimbursement for medical insurance premiums and out-of-pocket medical expenses paid by you, this Documentation of Medical Coverage form MUST be returned to Preferred Benefit Administrators. All reimbursement requests will require a QSEHRA Reimbursement Request form attesting that you continue to be covered under a medical insurance plan, in accordance with QSEHRA requirements, and will require supporting documentation to obtain reimbursement.

PERSONAL INFORMATION	
Employee Name	**Email Address**
Employee Address	
Employee Member ID Number	**Daytime Phone Number**

DOCUMENTATION OF MEDICAL INSURANCE COVERAGE		
Insurance Company Name	**Name of Primary Insured**	**Effective Date**

Important: In order to document your QSEHRA file, you must submit this completed form along with a copy of the front and back side of your medical insurance identification card.

☐ By checking this box and signing below, I attest that I am covered by a medical insurance plan that provides Minimum Essential Coverage (MEC) as defined by the Affordable Care Act (ACA).

☐ By checking this box and signing below, I hereby certify that the above information is accurate. I hereby authorize Preferred Benefit Administrators, Inc. to obtain necessary information from all physicians, hospitals, insurance companies, employers and all other agents, in order to adjudicate claims for reimbursement under the Qualified Small Employer Health Reimbursement Account (QSEHRA) established by my employer.

_____ _____

Employee Signature **Date**

Submit completed form to:
PREFERRED BENEFIT ADMINISTRATORS, INC.
P.O. Box 916188, Longwood, Florida 32791-6188

Fax: (407) 786-2999
Email: Claims@PreferredTPA.com
Toll Free: 1-888-524-2777