

Qualified Transportation Plan Reimbursement Claim Form

Employer Name: _____

Employee Name: _____ SSN: ____/____/____

Phone: _____ Email: _____

Qualified Parking Expense monthly reimbursement cannot exceed \$220/month

Name of Parking Facility	Month Service Incurred	Address of Parking Facility	Amount Incurred

Total Parking Expense Incurred: \$ _____
 Attach appropriate receipt(s) and submit with this form.

Qualified Transit Pass/Commuter Highway Vehicle Expense monthly reimbursement cannot exceed \$115/month

Name of Transit Provider	Month Service Incurred	Describe Expense	Amount Incurred

Total Transit Expense Incurred: \$ _____
 Attach appropriate receipt(s) and submit with this form.

Read carefully: The undersigned participant in the Plan certifies that all expenses for which reimbursement is claimed by submission of this form were incurred during the period while the undersigned was covered under the Employer's Qualified Transportation Plan with respect to such expenses and that all expenses for which reimbursement is claimed by submission of this form were incurred for any parking on or near the business premises of the Employer, on or near a location from which participant commutes to work, and/or for regular daily direct commute from home to work and return. The undersigned 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 this Plan, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature _____ **Date** _____