TRANSPORTATION FRINGE BENEFIT PLAN
REQUEST FOR REIMBURSEMENT FORM

Employee Name ____________________________ ID or SS # ______________________ Employer ________________________________

Daytime Phone # ____________________________ Home Address ____

Number/Street City State Zip

☐ Please check if this is a new address

Qualified Parking, Transit Pass, Commuter Highway Vehicle (Vanpooling) Reimbursement Request

- **Qualified Parking** covers parking on or near the employer's business premises or at a location from which the employee commutes to work.
- **Transit Passes** are tokens, fare cards, passes, vouchers, etc. used for transportation on mass transit facilities or provided by any person in the business of transporting persons for compensation or hire in a highway vehicle carrying at least 6 adults (excluding driver).
- **Vanpooling** is transportation in a commuter highway vehicle provided by an employer for travel between the employee's home and place of employment.

Date of Service From m/d/y to m/d/y	Provider Name	Type of Expense	Amount of Reimbursement Request
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			

Total: ___________

PLEASE NOTE: Receipts are required for reimbursement of all expenses, unless a receipt is not provided in the ordinary course of business (e.g., metered parking) and you certify by your signature below to the type and amount of expenses incurred. You have 180 days from the time of purchase to submit expenses. Reimbursements will be paid up to the monthly maximum. Your employer has the right to refuse reimbursement if there is reason to doubt your certification.

I certify that:

- The statements and representations in this Reimbursement Form are complete and true.
- I am requesting reimbursement for the purposes of commuting to and from work.
- The services listed above occurred on the dates indicated.
- Expenses listed are qualified expenses under my employer's Transportation Fringe Benefit Plan (the "Plan").
- These expenses have not been reimbursed and are not reimbursable under another plan.
- These expenses have not been reimbursed previously under this Plan.
- I authorize a deduction in my account in the amount of the reimbursement requested.

____ _______________

Employee Signature (You must sign this form to be reimbursed.) Date

Claim confirmation: You can easily view your claim status 24 hours a day, 7 days a week by checking the website at www.benefitsolved.com. If you choose to mail your claim, please do not fax the same claim. Claims may be faxed to 800-379-5670. If faxed, allow 2 business days before checking the website or calling for the status of your claim.

Infinisource has incorporated the HIPAA Privacy Requirements to reflect our organization's business practice regarding your insurance coverage.

Fringe Benefits Administration • PO Box 488 • Coldwater, MI 49036-0488
866-370-3040 • Fax: 800-379-5670 • www.infinisource.net • E-mail: fsa@infinisource.net

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