

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.
- **Bicycle Commuting** covers expenses related to regular bicycle use for a substantial portion of the travel between the employee's home and place of employment – up to \$20 per month – in those months where the employee receives no other benefits under the Transportation Fringe Benefit Plan. These expenses include bicycle purchase, improvements, repairs and storage. **Please review Plan materials to determine if your employer offers this benefit.**

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. 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 solely for the purposes of my own 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 at www.infinisource.net. If you choose to mail your claim, please do not fax the same claim. Claims may be faxed to 800-379-5670. Keep the fax confirmation for your records. If faxed, allow 48 hours before checking the website or calling for the status of your claim.

