

TRANSPORTATION & PARKING CLAIM FORM



Employees participating in the program only

Employer: _____

Employee: _____ SSN: xxx-xx-_____

Street: _____ City: _____

State: _____ Zip: _____ Phone: _____

Email: _____

Complete amount for each month to be reimbursed.

	Transit \$	Parking \$			Transit \$	Parking \$
January				July		
February				August		
March				September		
April				October		
May				November		
June				December		

- All claims require copies of receipts showing date and service.
- All claims must be received by Monday to be included in that week's processing.
- Direct deposit payments are processed weekly (Wednesday).
- Checks are processed at least twice a month (every other Wednesday).
- Please allow 3 business days to receive your check. Minimum payment is \$20.00.

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's Plan. I have not been reimbursed from any other source offered by my employer. None of these expenses have previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. Additionally, I am aware that unused funds may be rolled-over to the next plan year or otherwise handled in accordance with the plan document and the current IRS law. I hereby request reimbursement for these expenses.

Participant's Signature: _____ Date: _____

Attach receipts and:

Mail to:		Fax to:		Scan and Email to:
Cafeteria Plan Advisors, Inc 420 Washington St. Suite 100 Braintree, MA 02184	OR	781-848-8477	OR	Info@cpa125.com