Qualified Transit Expense Reimbursement Form

Page____ of____

EMPLOYEE NAME: LAST | FIRST | MIDDLE INITIAL | COMPANY NAME

LAST FOUR DIGITS OF SOCIAL SECURITY NO. | DAYTIME PHONE NUMBER | EMAIL ADDRESS ❍ check if new

HOME ADDRESS: STREET ❍ check if new | CITY | STATE | ZIP

To the best of my knowledge and belief, my statements for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred as an active participant in this Transit Plan. I certify that these expenses have not already been reimbursed. If there is a discrepancy between the total amounts of receipts requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts.

X

EMPLOYEE SIGNATURE VERIFICATION (Receipts will not be processed without signature) **DATE**

STEP 1: This section of the reimbursement form must be completed only for eligible expenses and only for expenses incurred during your plan year. You must have been a participant in the plan at the time the expense was incurred. The incurred date of the expense is the date of service. This form is for Qualified Transit Expenses Only.

Receipts must include the following information:

❍ Date of Service
❍ Transit Provider
❍ Transit Location
❍ Amount of Service

❍ **Be sure to total your expenses**
❍ **Canceled checks/credit card statements are not acceptable forms of documentation**

DATE OF SERVICE	TRANSIT PROVIDER	TRANSIT LOCATION	AMOUNT
From: / / To: / /			$. ❍ Check this box if no receipt was provided in the normal course of business (transit meter or drop box).
From: / / To: / /			$. ❍ Check this box if no receipt was provided in the normal course of business (transit meter or drop box).
From: / / To: / /			$. ❍ Check this box if no receipt was provided in the normal course of business (transit meter or drop box).
From: / / To: / /			$. ❍ Check this box if no receipt was provided in the normal course of business (transit meter or drop box).

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STEP 2: Please fax to 877-767-8804 for the quickest processing time, complete, sign and fax your reimbursement form and all necessary documentation. A cover page is not required. If you prefer to mail your form and receipts, please send to PlanSource, P.O. Box 160940, Altamonte Springs, FL 32714. Please keep all receipts and original documentation as required by the IRS.