Health Choices, FSA
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Transportation Spending Account Claim Form

Employee:_____ Email Address:_____

Employee SSN#:_____ Employer: _____

Please include documentation in the order you have listed and attach to this claim form.

Qualified Parking 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.

Date(s) of Service from m/d/y to m/d/y	**Provider Name**	**Type of Expense**	**Amount of Reimbursement Request**
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
		Total:	

Qualified Transit Pass, Vehicle (Vanpooling) Reimbursement Request

• ***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 six adults (excluding driver).

Date(s) of Service from m/d/y to m/d/y	**Provider Name**	**Type of Expense**	**Amount of Reimbursement Request**
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
		Total:	

NOTE: Receipts are required for reimbursement of all expenses, unless a receipt is not provided in the ordinary course of business (i.e., 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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date:_____