

<b>ID Section</b> <span style="float:right"><i>PLEASE PRINT. Form must be completed entirely and signed to qualify for reimbursement.</i></span>		
Employer:	Division/Branch:	Social Security Number: _____ - _____ - _____
Employee Name:		Plan Year Ending: _____ / _____ / _____

**Parking Reimbursement Section** *(Copies of Bills or receipts must be sent and individually listed below).*

**IMPORTANT:** Use separate forms if expenses are from different plan years. Plan must receive all requests for the prior plan year before the end of the grace period.

Date of Service	Name of Service Provider	Expense Description (e.g. garage, lot, meter, etc.)	Net Amount of Expense (\$240 maximum per month)
			\$
			\$
			\$
			\$

**TOTAL PARKING EXPENSE REQUEST (this page only, use as many forms as needed):** \$

**Please keep your originals and fax or mail 8 ½" x 11" copies** of bills or receipts for the parking expenses included on this form together with this form. The plan is unable to return documents submitted.  
*Please Note: an eligible receipt must include ALL of the following: Provider's Name, Date of Service, Type of Service & Cost of Service.*

**Transit Reimbursement Section** *(Copies of Bills or receipts must be sent and individually listed below).*

**IMPORTANT:** Use separate forms if expenses are from different plan years. Plan must receive all requests for the prior plan year before the end of the grace period.

Date of Service	Name of Service Provider	Expense Description (e.g. bus pass, car pool, van pool, etc.)	Net Amount of Expense (\$125 maximum per month)
			\$
			\$
			\$
			\$

**TOTAL TRANSIT EXPENSE REQUEST (this page only, use as many forms as needed):** \$

**Please keep your originals and fax or mail 8 ½" x 11" copies** of bills or receipts for the public transit expenses included on this form together with this form. The Plan is unable to return documents submitted.  
*Please Note: an eligible receipt must include ALL of the following: Provider's Name, Date of Service, Type of Service & Cost of Service.*

**Participant's Statement and Signature** *PLEASE READ CAREFULLY:*

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is requested by submission of this form were incurred during a period while I was covered under the Company's Pre-Tax Transportation Reimbursement Plan with respect to such expenses and that these expenses have not been reimbursed or are not reimbursable under any other plan coverage. I, the undersigned, fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request which is provided by me and that unless an expense for which payment or reimbursement is requested is a proper expense under the plan, I may be liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid from the plan which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original.

**X** \_\_\_\_\_ \_\_\_\_\_  
 Plan Participant's Signature Date