COMMUTER BENEFIT PLAN (CBP): REIMBURSEMENT CLAIM FORM *(PLEASE PRINT CLEARLY)*

PART 1	PART 2 ☐ *Check here if address has changed and provide new information below.*
Employee Name:	**Street or PO Box:** **Apt #**
Member ID:	
Employer:	**City, State, Zip:**

PART 3

Provider of Qualified Expense	Month of Service	Year of Service	Expense Type	Total Monthly Amount	Office Use Only	
			☐ MST ☐ PRK	$		
			☐ MST ☐ PRK	$		
			☐ MST ☐ PRK	$		
			☐ MST ☐ PRK	$		
			☐ MST ☐ PRK	$		
			☐ MST ☐ PRK	$		
			☐ MST ☐ PRK	$		
			☐ MST ☐ PRK	$		
			☐ MST ☐ PRK	$		***GRAND TOTAL***
			☐ MST ☐ PRK	$		
			☐ MST ☐ PRK	$		***$***
			☐ MST ☐ PRK	$		

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PART 4

CERTIFICATION: I request reimbursement for my workplace commuting expenses as itemized above. I understand that these expenses must qualify for reimbursement under Internal Revenue Code Section 132(f). I certify that each expense listed above was for an eligible service provided during the indicated month and was for qualified workplace commuting expenses as defined in the Commuter Benefit Plan and was not purchased with a benefit card. I also hereby certify that, for each expense listed above for which I have not attached a receipt or bill, documentation verifying the expense is not provided in the ordinary course of business by the vendor of the service.

Sign Here ***Signature Required:*** ***Date:***

(Cut along dotted line)

INSTRUCTIONS FOR SUBMITTING YOUR COMMUTER BENEFIT PLAN CLAIM:

1. **PART 1** *must* be completed in full.
2. **PART 2** should only be completed if your address has changed.
3. **PART 3** *must* be completed in full. Each line item on your claim form must indicate expenses for a *single* month for either Qualified Mass Transit (MST) or Qualified Parking (PRK). If documentation of your expenses is available from your provider, you must attach a copy of bills, statements, receipts or cancelled checks. (Please retain originals for your personal income tax records.) The statement of expense *must* include the following information:
   - The name of the provider;
   - The type of service provided;
   - The date(s) the service was provided;
   - Your out-of-pocket cost for the service.
4. **PART 4** must be signed and dated after reading the statement.
5. Submit your completed claim form and related documentation to: ATTN: Claims Department
   Benefit Resource, Inc.
   2320 Brighton-Henrietta Townline Rd.
   Rochester, NY 14623-2782
   Fax: (585) 427-9340

IMPORTANT CLAIM SUBMISSION REMINDERS:

- **Eligible claims must be received by Benefit Resource, Inc. within 180 days after the service is provided.**
- **The request for reimbursement must be based on the date when the service was provided, not on the date when a payment was made.**
- **An expense paid with a benefit card or that has been reimbursed from any other source cannot be submitted for reimbursement.**
- **Expenses that are <u>not</u> eligible for reimbursement include: highway tolls, bridge tolls, and taxicab fares.**

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Phone: (800) 473-9595
Website: www.BenefitResource.com