



**Transportation Benefit Plan
Reimbursement Claim Form**

Fax Claim Form to: FlexSave at 440-878-4890

Or Mail to:

*FlexSave
MZ: 04-2W-8317
2060 East Ninth Street
Cleveland, OH 44115-1355*

Employer: _____

Employee Name: _____ Social Security Number: _____ - _____ - _____

Phone: _____ E-mail: _____

(You may copy this claim form for future use)

Qualified Parking Expense			
Name of Parking Facility	Month Service Incurred	Address of Parking Facility	Amount Incurred*
Total Amount:			\$

*Monthly amount cannot exceed indexed amount. Indexed amount for 2008 is \$220.00.

Qualified Transit Pass/Commuter Highway Vehicle Expense			
Name of Transit Provider	Month Service Incurred	Expense Description	Amount Incurred*
Total Amount:			\$

*Monthly amount cannot exceed indexed amount. Indexed amount for 2008 is \$115.00.

Read Carefully: The undersigned participant in the Plan certifies that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Tax-Free Transportation Program with respect to such expenses and that all expenses for which reimbursement is claimed by submission of this form were incurred for any parking on or near the business premises of the Employer, on or near a location from which participant commutes to work, and/or for regular daily direct commute from home to work and return. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed as a proper expense under this Program, the undersigned may be liable for payment of all related taxes including federal, state or local income tax on amounts paid from the Program which relate to such expense.

Employee's Signature

Date