FlexSave™
Flexible Spending Program

Transportation Benefit Plan Reimbursement Claim Form

Customer Service – 800.525.9252
Weekdays 8 a.m – 5 p.m. EST

Employer: _____

Employee Name: _____

Phone: _____

(You may copy this claim form for future use)

Claim Submission Information:
Fax Claim Form and Receipts to: 440.878.4890
Or Mail to:

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

Qualified Parking Expense

Name of Parking Facility	Month/Year Service Incurred	Address of Parking Facility	Amount Incurred*
		Total Amount:	**$**

Monthly amount cannot exceed indexed amount.

Qualified Transit Pass/Commuter Highway Vehicle Expense

Name of Transit Provider	Month/Year Service Incurred	Expense Description	Amount Incurred*
		Total Amount:	**$**

Monthly amount cannot exceed indexed amount.

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible transit or parking benefits that are my own personal expenses incurred while I was a participant in the plan. I have already received these products and services and have not been previously reimbursed for these expenses and I will not seek reimbursement of these expenses from any other plan or party. In addition, the expenses for which reimbursement is sought will not be claimed as tax deductions on my personal tax return. I understand that if an expense is determined to be ineligible, I am responsible for reimbursing the plan(s) for any such expense. All expenses incurred for transit or parking were incurred for parking at or near the business premises of my employer, or near a location from which I commute to work, and/or for regular daily direct commute from home to work and return. I certify that if no receipt is provided for commuter expenses, this service provider does not provide receipts (such as payments made by token/ticket machine, meter or cash box). If this is a Public Transportation expense, then the pass for this service in this amount is not available for purchase from my employer or plan service provider.

_____ _____

Employee's Signature **Date**