



PARKING & TRANSIT CLAIM FORM

Part 1: Employee Information:

Employee Name: (First) _____ (Last) _____

Social Security Number: _____ - _____ - _____ Home Phone _____

Employer Name: _____ E-mail _____

Part 2: Address Change Section: (Only complete this section if you have had a change in address.)

Address _____, _____, _____, _____

Part 3: Employee Certification for Reimbursement:

I certify these expenses are correct and represent my responsibility of any billing. If the parking facility or mass transit authority provides bills or receipts to support the expenses listed below, I acknowledge that I have ATTACHED those bills or receipts. I certify that I have not been reimbursed for these expenses from this Plan, nor have they or will they be reimbursed by any other source. I also certify that the expenses mentioned below are strictly work-related expenses. I understand any expenses reimbursed under this Plan can not be claimed on my personal income tax return.

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 _____

Transit/Vanpooling – Eligible transit expenses include transit passes, tokens, fare cards, vouchers or similar items entitling you to travel on a mass transit service to your place of work (i.e. subway, bus, or train). Eligible vanpooling expenses include travel on a commuter highway vehicle between your residence and place of work. If provided, you must attach supporting documentation that states the method of transportation and your portion of the amount paid.

Parking – Parking expenses are eligible for reimbursement if they were work-related and incurred near your place of work or near a location from which you commute to work or vanpool. If provided, you must attach supporting documentation that includes the dates of parking, the name of the parking facility, and your portion of the amount paid.

Part 4: Itemized List of Expenses:

Month & Year of Service:	Claim Amount:	Type of Service:
_____/____/_____	\$ _____	<input type="checkbox"/> Parking or <input type="checkbox"/> Transit
_____/____/_____	\$ _____	<input type="checkbox"/> Parking or <input type="checkbox"/> Transit
_____/____/_____	\$ _____	<input type="checkbox"/> Parking or <input type="checkbox"/> Transit
_____/____/_____	\$ _____	<input type="checkbox"/> Parking or <input type="checkbox"/> Transit

Total: \$ _____ (\$25.00 minimum claim amount)

Maximum claim and reimbursement per month: Parking \$230.00 Transit: \$230.00

Attach and submit **copies** of all supporting documentation for the items listed above. Incomplete forms will be denied for additional information. Account information and verification of claim receipt is available at www.sheakley.com/flex/participants. Please allow 24 to 48 hours after faxing to verify receipt. Customer Service is available 8:00 a.m. to 5:00 p.m., Eastern Standard Time toll free at 800-877-6630. **To set up direct deposit (if applicable) attach a voided check with your first claim.**

FOR QUICKEST REIMBURSEMENT FAX TO 513-326-8082 or EMAIL: 125@sheakley.com

Or mail to: Sheakley Flexible Benefits Division
One Sheakley Way . Cincinnati . OH 45246