

Employer – \_\_\_\_\_

To expedite your claim:

- Provide all appropriate information
- Review Total Expense Amounts

Employee Name \_\_\_\_\_ Employee ID Number or SS# \_\_\_\_\_

New Address? Yes  No  If yes please provide

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Email \_\_\_\_\_

### Qualified Parking Expense

Qualified Parking Expense			
Name of Parking Facility	Month Service Incurred	Address of Parking Facility	Amount Incurred
<b>Total Amount:</b>			

### Qualified Transit Pass/Commuter Highway Vehicle Expense

Qualified Transit Pass/Commuter Highway Vehicle Expense			
Name of Transit Provider	Month Service Incurred	Expense Description	Amount Incurred
<b>Total Amount:</b>			

Attach a receipt/statement from the parking facility or transit provider showing amount and dates of service.

The undersigned participant in the Program 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 Employer'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 is 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Send completed form with receipts attached to:  
**Employee Benefit Concepts, Inc.**  
**P.O. Box 2365**  
**Farmington Hills, MI 48333**  
[claims@employeebenefitconcepts.com](mailto:claims@employeebenefitconcepts.com)  
**Fax: 248-855-2454**  
**Phone: 248-855-8040 Section 125 Department**