COMMUTER EXPENSE REIMBURSEMENT REQUEST FORM FAX: 1-888-207-2310

Employee Info			
	Your Name	Your Employer	
	Street Address	Last 4 # of your SSN	Birth Date MM DD
	City State & Zip Code	Your Email Address	

CHECK ONE AND COMPLETE:

☐ **PARKING EXPENSES** Commuter Parking claims must be submitted within 180 days (6 months) of the date of the expense and within a limited time (usually 60 to 90 days) after you terminate participation, whichever is earliest.

Parking Provider_____ Date _____ Amount Claimed $_____

Parking Provider_____ Date _____ Amount Claimed $_____

Initial here if applicable: _____ I am unable to provide supporting documentation because the expense was paid at a meter, token/ticket machine, cash box or similar no-receipt situation.

☐ **MASS-TRANSIT EXPENSES – EXCEPTION ONLY – PLEASE READ:** I am requesting reimbursement of my transit expenses because my Benefits Card has been lost or stolen. To report your card as lost or stolen, please call 1-866-679-7649. The expenses must have been incurred within 5 days before or 15 days after the card is reported as lost or stolen and the claim must be made within 30 days of the date the card was reported lost or stolen. This exception is limited to once per year without additional documentation, such as a copy of a police report.

Transit Provider_____ Date _____ Amount Claimed $_____

Transit Provider_____ Date _____ Amount Claimed $_____

I hereby certify, understand and agree that: The expenses submitted for reimbursement have not been reimbursed or paid previously and I will not seek payment or reimbursement under any other benefit plan for these expenses; These expenses were incurred during the coverage period by either me or my eligible dependents; I understand and agree that the commuting expenses of my spouse and other dependents are not eligible for reimbursement from this plan; I assume the responsibility to maintain substantiating documents for all claims; I understand that this claim form will not be returned to me and I am responsible for retaining my own copy; I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim; I am liable for payment of any taxes and penalties, federal, state or local, related to expenses claimed or paid that are not eligible expenses under the Plan(s); These expenses cannot be claimed as credits or deductions on my personal tax return if reimbursed or paid from the Plan(s); It is my responsibility to obtain and report to the IRS the Identification Number of any and all dependent care providers to whom I have paid for services which were submitted for reimbursement under this Plan; I have received a copy of the Summary Plan Description(s) and understand that this claim is subject to the terms and requirements of the Plan(s), including but not limited to eligibility, coverage period and claims filing deadline; I may receive notifications by email instead of mail and I understand that I must notify FlexToday in writing to rescind this authorization to send notifications by email, and; My digital signature on this form will be accepted as binding with the same weight and consideration as a pen and paper signature.

Employee Sign Here	Date Signed

FlexToday, Inc. • PO Box 16099 • Fresno, CA 93755-6099 • Ph: 559-432-6800 or 800-995-5373
Claims Fax 1-888-207-2310 • **Secure Claims Portal Link**

You can send claims by fax, mail or electronically (scanned) at the Secure Claims Portal. **We do not accept claims by email**. Unidentified files and files executable formats (.exe, .zip, .eml, .com, .net, .html, vbs, etc.) will be deleted without opening or notice and will not be considered a claim submission.