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

Commuter Choice 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**.

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

Is this a new mailing address and/or email address? ☐ YES ☐ NO

What type of claim is this? ☐ MASS-TRANSIT ☐ VANPOOL ☐ PARKING

PROVIDER	COST	SERVICE DATE (One Month Per Line)
	$	
	$	
	$	

☐	**PARKING CLAIM WITHOUT SUPPORTING DOCUMENTATION** This is a Parking Claim and 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.
☐	**REIMBURSEMENT OF MASS-TRANSIT EXPENSES** I am requesting reimbursement because commuter benefit debit cards are not accepted as compliant payment by this transit vendor/operator, it is a cash-only agency and/or my Benefits Debit Card transaction failed.

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.