Custom Design Benefits

www.CustomDesignBenefits.com

Flexible Spending Account – Parking/Transportation Claim Form

Employer: _____

Employee Name: _____ Employee or Social Security Number: _____

☐ Check here if new address Address:_____

City:_____ State:_____ Zip:_____ Date of Birth:_____

E-mail Address_____ Phone: _____

TO EXPEDITE YOUR CLAIM: PROVIDE *ALL* APPROPRIATE INFORMATION, **INCLUDING PHOTOCPOIES AND RECEIPTS,** AND REVIEW THE TOTAL AMOUNTS BEFORE SUBMITTING YOUR CLAIM. PLEASE NOTE ANY CLAIM RECEIVED LESS THAN 24 HOURS PRIOR TO YOUR SCHEDULED REIMBURSEMENT DATE WILL BE PROCESSED ON THE NEXT SCHEDULED REIMBURSEMENT DATE.

Qualified Parking Garage and Meter Expenses

From: _____ **To:** _____ **Amount to be Reimbursed: $**_____

□ **Parking Facility Name:** _____
□ **Metered Parking**

I hereby certify that I have incurred the expenses indicated above. Any additional burden of proof will remain my responsibility if I am required to provide substantiation.

Employee Signature: _____ Date: _____

Qualified Mass Transit and Auto Share Expenses

From: _____ **To:** _____ **Amount to be Reimbursed: $**_____
□ **Mass Transit or Auto Share Provider:** _____
□ **Bus Fare**

I hereby certify that I have incurred the expenses indicated above. Any additional burden of proof will remain my responsibility if I am required to provide substantiation.

Employee Signature: _____ Date: _____

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the expenses have not been reimbursed or are not reimbursable under any other plan coverage. The undersigned fully 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 the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. Please do not include original receipts since, after the claim is substantiated, Custom Design Benefits does not keep receipts on file.

_____ _____

Employee's Signature **Date**

For immediate service, please fax to (513) 598-2901 or E-Mail to Flexclaims@CustomDesignBenefits.com
You may also mail to Custom Design Benefits, Inc., 3737 West Fork Road, Cincinnati, OH 45247
For assistance, you may call (800) 598-2929 or (513) 598-2929
View your account online at www.myflexonline.com