CBIZ Flex

Transportation/Parking Claim Form

Version 11.01.08

Employer:			
Employee:		**SSN:**	- -
Email:		**Phone:**	( ) -

Qualified Parking Expense

Name of Parking Facility	Month Service Incurred	Address of Parking Facility	Amount Incurred*

**Monthly amount can not exceed indexed amount.*	**Total Parking Expense Claim**	

Qualified Transit Pass/Commuter Highway Vehicle Expense

Name of Transit Provider	Month Service Incurred	Expense Description	Amount Incurred*

**Monthly amount can not exceed indexed amount*	**Total Transit Expense Claim**	

Read Carefully

The undersigned participant in the Plan certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the Company's Transportation/Parking Account with respect to such expenses and that the expenses have not and will not be reimbursed under any Transportation/Parking Account Plan The undersigned fully understands that he or she 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, and or local income tax on amounts paid from the Plan which relate to such expense.

Employee Signature **Date**

Claim Forms can be mailed or faxed to:

CBIZ Payroll, Attn: Flex 310 First Street, Suite 600 Roanoke, VA 24011 *(Please keep a copy for your records)*

Fax: **800-584-4185** Phone: 800-815-3023 option 4 Email: cbizflex@cbiz.com