Commuter/ Parking Reimbursement Claim Form

Employer_____Employee Name_____

Social Security#_____Phone Number_____

Your e-mail Address (for claim-related matters only)_____

Claim Form and Filing Procedures

Complete all sections of the claim form and sign and date where indicated

Unreimbursed Transit Expense Claims			
Expense Incurred Date/Date Range	Type of Service (Note Type) Parking Garage Van Pooling Bus Fare** Meter Parking**	Name of Parking Facility or Service Provider	Net Amount Incurred*
Total Unreimbursed Transit Expense Claims			

**Affidavit: Meter Parking or Bus Fare –Signature Required if No Receipt for Expense: I hereby certify that I have incurred the expenses indicated above in the use of Metered Parking or Bus fare. If I am required to provide a receipt, then any additional burden of proof will remain my responsibility.

Affidavit Signature_____

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 Qualified Transportation Plan with respect to such expenses and that the transit expenses have not been reimbursed or are not reimbursable under any other circumstances. (Note: All claims must total a minimum of $10.00 to be reimbursed in the period submitted; otherwise, they will be held until whatever subsequent period in which the accumulated total claims equal or exceed $10.00.) The participant agrees to attach all related receipts to validate all reimbursements noted herein (per IRS regulations cancelled checks are NOT allowed as receipts). 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.

_____ _____

Employee Signature Date

Remit Claim to:

BMS LLC * P.O. Box 43653* Louisville, KY 40253-0653

YOU CAN FAX YOUR CLAIM TO: (502) 244-1162 OR E-MAIL TO: claims@bmsllc.net

www.bmsllc.net - Visit our website to create an online FSA claim submission!