

Commuter/ Parking Reimbursement Claim Form

Employer	Emp	Employee Name		
Social Security	/#Pho	Phone Number		
Your e-mail Ad	ddress (for claim-related matters only)			
_	<u>Claim Form and Filin</u> **Complete all sections of the claim form a		nere 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	
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				
submission of thi Transportation P reimbursable und period submitted or exceed \$10.00 regulations cance responsible for t undersigned, and the undersigned	LLY participant in the Plan certifies that all expensis form were incurred during a period while the plan with respect to such expenses and that the der any other circumstances. (Note: All claims to otherwise, they will be held until whatever subsection.) The participant agrees to attach all related receiled checks are NOT allowed as receipts). The sufficiency, accuracy, and veracity of all infection that unless an expense for which payment or reimal that unless an expense for which payment or reimal that unless an expense for which payment or reimal that unless an expense for which payment or reimal that unless an expense for which payment or reimal that unless an expense for which payment or reimal that unless and expense in the related to such expense.	undersigned was cove e transit expenses have must total a minimum equent period in which ceipts to validate all re- undersigned fully unde ormation relating to to mbursement is claimed	ered under the Cor ye not been reimb of \$10.00 to be r the accumulated to imbursements note erstands that he or his claim which is I is a proper expens	npany's Qualified ursed or are not eimbursed in the total claims equal ed herein (per IRS she alone is fully provided by the se under the Plan,
	Employee Signature			

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!

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