Transportation Benefit Plan
Parking Expenses Claim Form

Employee Name	Mail, fax or email this claim form along with documentation to:
Address	Benefit Extras, Inc. PO Box 1815 Burnsville, MN 55337 Phone (952) 435-6858 Fax: (952) 435-8435 flex@benefitextras.com
City State Zip	**PLEASE RETAIN A COPY FOR YOUR RECORDS**

Mass Transit Expenses must be purchased using your WEX Health® Prepaid Benefits Card. Cash reimbursements are not allowed.

Parking Fee Request: These services must have been incurred during the current plan year. You must attach a copy of the monthly parking receipt or bill, verifying the month of parking, name of person receiving service and the cost.

Date	Type	For Whom	Cost
____________	____________________	____________	$___________
____________	____________________	____________	$___________
____________	____________________	____________	$___________
	Total Parking Fee Requested:		**$___________**

Employee Certification: To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Transportation Fringe Benefit Parking Account. I am claiming reimbursement only for eligible expenses incurred by myself during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source. I hereby authorize my Transportation Parking Account to be reduced by the amount(s) shown above.

☐ The provider of the transportation services indicated above does not issue statements or receipts in the normal course of its business. By checking this box and signing the claim form, I am certifying that the claims indicated were incurred by me and were for expenses where documentation is not provided in the normal course of business.

Employee Signature ______________________________________Date_______________