



P.O. Box 11657 Pleasanton, CA 94588 888 327 2770 fax 925 460 3929

### CLAIM FORM: QUALIFIED TRANSIT/PARKING REIMBURSEMENT

To file a claim for expenses, please request a copy of a receipt for services from the qualified transit / parking expense provider. The receipt must include the following information:

- The dates of service (example: January 1 – 31)
- The name of the service provider. (example: Big City Parking)
- A description of the service, or expense. (example: Monthly parking)
- The amount or cost of the service provided. (example: \$50)
- Your name as the person that incurred the expense. (example: invoice with your name on it)

Attach a copy of the receipt(s) for eligible transit/parking expenses to this form and mail to:

Employee Benefit Specialists (EBS), Inc.  
 Fax: (925) 460-3920  
 Mail: PO Box 11657, Pleasanton, CA 94588

*Be sure to keep a copy of your receipts and claim forms for your personal records. These will not be provided to you from EBS as they are stored offsite or scanned and destroyed.*

#### Claims Information

Employer Name: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (        ) \_\_\_\_\_

Dates of Service	Type of Transit Expense for Eligible Expense	Amount requested to be Reimbursed
EXAMPLE: January 1 –31, 2005	Parking (for example purposes only)	\$50.00 (for example purposes only)

I certify that the charges for which I am requesting reimbursement have been incurred by me. Furthermore, I declare that I am requesting reimbursement only for expenses that have not and will not be paid under any other benefit plan or program; and that I am solely responsible for the accuracy and veracity of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Qualified Transit Expense Plan.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_