



CLAIM FORM – TRANSIT / PARKING

1. Instructions (incomplete claim forms will not be processed)

- Complete the Employee / Employer Information requested under Section 2.
- Fully complete all fields in Section 3. **Claim forms with incomplete information will be rejected.** Please itemize each expense. Additional pages may be attached. Receipts must contain the dates of service, the name of the service provider, description of the expense and the amount.
- Under Section 4, read the Employee Authorization carefully and sign noting your agreement.
- **Keep complete copies of all receipts and forms submitted to EBS for audit purposes.** EBS is not responsible for providing copies to participants.
- Completed claim forms should be **faxed to 925.460.3929 (preferred)** or mailed to the following address:
EBS, P.O. Box 11657, Pleasanton, CA 94588
Fax: 925.460.3929 (preferred)

2. Employer / Employee Information

New Address? Check the box if the address listed below is new

Employer Name _____

Employee Name _____ SSN _____

Street Address _____

City / State / Zip Code _____ Daytime Phone _____

3. List of Eligible Expenses

Date of Service	Type of Expense	Amount Requested
1/1/10 - 1/31/10	TRANSIT / PARKING	\$230
Total Amount Requested		

4. Employee Authorization

I certify that I (and/or my eligible dependents) have incurred expenses for which reimbursement is sought under my Commuter Benefits and that these expenses have been incurred during the plan year. Furthermore, I declare that I am requesting payment 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 of all information relating to this claim. I authorize the Employer to reimburse the amount requested from my Commuter Benefit plan.

Employee Signature _____ Date _____