

MAIL TO:
 PayFlex Systems USA, Inc.
 P.O. Box 3039
 Omaha, NE 68103-3039
 (402) 345-0666



**PARKING AND
 TRANSPORTATION
 CLAIM FORM**

FAX TO:
 PayFlex Systems USA, Inc.
 (402) 231-4310
 (No Cover Page Required)
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WAIT! Did you know that you can file this claim online? Go to www.healthhub.com and select Express Claims.

Employee Name _____ **Member Number** _____
 (This may be your SSN or employer assigned number)

Employer Name _____

Note: To make an address change, please contact your HR/Benefits office. For security purposes, we cannot accept address changes directly.

Transportation Claims

You may submit your claim for reimbursement at the end of each month. Complete this form and attach an itemized statement from the provider showing the amount of your expenses. The itemized statement must include the provider name/address, date the service was provided, description of the type of service provided, and the dollar amount. The amount requested on this claim form below may not exceed these amounts per month:

- Parking Limit: 1/1/2009 – 12/31/2010 is **\$230 per month**
- Transit Passes/Van-pool Combined Limit: 3/1/2009 – 12/31/2010 is **\$230 per month**

*******Information below must be completed—“See Attached” is not acceptable.*******

Parking

Parking Service Provider Name	Month of Service		Amount
	Month	Year	
Total			\$

Transportation

Transit Passes-Bus, Ferry, Rail, Subway, Van-pooling Provider Name	Month of Service		Amount
	Month	Year	
Total			\$

I certify that I have actually incurred these eligible expenses. I understand that expense incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature _____ **Date** _____

*******Make copies for yourself, since these documents will not be returned. If you fax your claim, keep the original.*******