Claim Form – Flexible Spending Account – Transportation/Parking Reimbursement *2012 Expenses*

Use this form to submit for reimbursement of eligible travel and parking expenses.

Employer / Company Name	Department / Division	Health Plans Member ID#	
Employee Last Name	Employee First Name (Subscriber)	M.I.	DOB (MM / DD / YYYY)
Street Address	City	State	ZIP Code
Email Address	( ) Home Phone Number	( ) Work / Mobile Phone Number	

Instructions

- You may submit claims monthly, quarterly, or annually. You may be reimbursed up to **$240.00 per month** for employee parking expenses, and up to **$125.00 per month** for transit passes, and commuter vanpool expenses.
- You must substantiate that these expenses were incurred by submitting monthly parking bills or daily parking ticket stubs, or receipts for transit passes or vanpool expenses. If receipts are not available, please contact your plan administrator for further information.
- Eligible expenses must be incurred during the plan year.

Claim Summary

Parking Expenses

Month & Year Incurred	Name of Garage or Lot	Total Amount of Expenses		Amount Over Monthly Limit *($240)*		Requested Reimbursement
			LESS		=	$
			LESS		=	$
			LESS		=	$

Transit Passes & Commuter Vanpool Expenses

Month & Year Incurred	Name of Transit or Vanpool	Total Amount of Expenses		Amount Over Monthly Limit *($125)*		Requested Reimbursement
			LESS		=	$
			LESS		=	$
			LESS		=	$
				CLAIM TOTAL		$

Please Read Carefully

The undersigned Plan Participant (Subscriber) certifies that all expenses claimed herein were incurred during a period of active coverage. The undersigned understands that he or she is fully responsible for the sufficiency, accuracy, and veracity of all information contained herein, and that if an expense claimed herein is not an eligible expense under the plan, the undersigned may be liable for the payment of all related taxes (including federal, state, or city income tax) on amounts paid by the plan which relate to said expense.

I certify that all items claimed herein comply with the Flexible Spending Account program, and said items have not and will not be covered by any other plan or program of any employer, or other party, and will not be reimbursed through a rebate program.

Employee Signature ***(required)*** Date

Print and submit this form to:

Health Plans, Inc.
Attn: Flexible Spending Dept.
PO Box 5199
Westborough, MA 01581

or fax to: 508-329-4815

Please retain a copy of this form and all related documentation for your records.

*Questions? Please call **800-343-7674, ext. 8416**, or submit your question online at **www.HealthPlansInc.com**, and click on* **Contact Us**.

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