



Transportation Fringe Benefit Plan Reimbursement Request Form

Name: _____ SS# _____

Address: _____

Location of Your Employer Worksite: _____

Instructions: Complete the information below for Transportation Expenses incurred or paid by you. You must provide bills, invoices, statements from an independent third party, parking receipts, or other evidence showing that the expenses were incurred or paid (canceled checks will not be accepted). Be sure to provide all information requested by this form. If the Form is incomplete, it will be returned to you. Please date and sign the Form, then send it along with your supporting documentation to:

HealthComp Administrators P.O. Box 45018 Fresno, CA 93718-5018; or, Fax#: (559) 499-2464

	Example	Expense #1	Expense #2	Expense #3	Expense #4
Date Transportation Service Provided or Paid	1/1/03 – 1/31/03				
Check Type of Transportation Expenses	<input type="checkbox"/> Parking <input type="checkbox"/> Transit Pass <input type="checkbox"/> Commuter Highway Vehicle				
Proof of Expense Attached? If not, explain why proof not available in ordinary course of business	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Total Expense	\$65				
Reimbursement Requested:	\$65				

To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following. I used the Transportation Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at the Employer. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid expenses under the Plan. I have not been reimbursed previously for these expenses under the Plan or any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit, or to claim reimbursement under another plan.

Employee's Signature

Date