AMERICAN BENEFITS GROUP
My Commuter Connect

CLAIM FOR PARKING REIMBURSEMENT

Please make copies and save for future claims filing

Name: _____ Last Four Digits of SSN: _____

Employer: _____ Email: _____

Parking Expense Claims

Period Covered From: To:	Name of Service Provider	Amount Incurred
	TOTAL PARKING EXPENSE CLAIM	$

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Section 132 commuter benefit plan with respect to such expenses and that the parking expenses have not been reimbursed and will not be reimbursed under any other fringe benefit plan. These benefits are only to be used for work related parking expenses and are not available to your dependents. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relates to such expense.

Employee's Signature: _____ Date: _____

Please submit this claim form along with receipts when available
(Receipts should indicate the dates of service, the name of the provider and the cost of the service.)

Fax Toll Free to 877-723-0147 or email to claims@amben.com

No Fax or Email? Mail to: American Benefits Group • PO Box 1209, Northampton, MA 01061-1209 • 800-499-3539