AMERICAN BENEFITS GROUP

COMMUTER PARKING – CLAIM FORM

Please make copies and save for future claims filing

Name: ______________________________ Last Four Digits of SSN: ______________________

Employer: ______________________________ Email: ______________________________

Commuter Parking Claims

Period Covered From To	Name of Service Provider	Amount Incurred
	TOTAL 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 commuter 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 commuter 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: ____________________

Cash Reimbursements are no longer allowable for Transit Expenses incurred after 12/31/2015.

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: 877-723-0147

No Fax Machine?

Mail to: American Benefits Group, PO Box 1209, Northampton, MA 01061-1209

800-499-3539