

Commuter Benefits Program Reimbursement Request Form

INSTRUCTIONS: Complete the information below for commuter expenses incurred or paid for by you. For information regarding commuter expenses that can and can not be reimbursed, see your Commuter Benefits Reference Guide). You must provide bills, invoices or statements from an independent third party, cancelled checks, parking receipts, used transit passes or other evidence showing that the expenses were incurred or paid.

Social Security Number	Date of Birth (00/00/00)
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Employer _____

Last Name _____ First Name _____

Home Address _____ City _____ State _____ Zip Code _____

Daytime Phone Number (Required) _____ E-mail Address _____

Be sure to provide all information requested, date and sign the form, then send it with your supporting documentation via FAX to FBMC at 1- 888-326-2658 or mail to FBMC, P.O. Box 1800, Tallahassee, Florida 32302-1800.

	TRANSIT	PARKING
Month Commuter Service was Provided	_____/_____ MONTH YEAR	_____/_____ MONTH YEAR
Description/Service Provider		
Receipt(s) <i>Lost your receipts? See options below</i>	<input type="checkbox"/> ATTACHED RECEIPTS <input type="checkbox"/> OPTION 1 <input type="checkbox"/> OPTION 2	<input type="checkbox"/> ATTACHED RECEIPTS <input type="checkbox"/> OPTION 1 <input type="checkbox"/> OPTION 2
Total Expense	\$ _____	\$ _____
Reimbursement Requested	\$ _____	\$ _____

RECEIPT OPTIONS - If you did not receive or have lost your receipt, you may choose:
Option 1 – I did not receive a receipt or other documentation or
Option 2 – I did receive a receipt or other documentation, but it’s no longer in my possession. I have not submitted it as proof of my expense for other purposes.

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 commuter benefit for which I am requesting reimbursement above only for the purposes of commuting to and from work at my 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 Transportation Expenses under the Program. I have not been reimbursed previously for these expenses under the Program. These expenses have not been reimbursed or are not reimbursable under 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. I authorize a deduction from my Commuter Benefits Account in the amount of the requested reimbursement.

Employee Signature _____ Date _____

**For questions, please contact FBMC Customer Service at 1-800-342-8017.
 Visit www.myFBMC.com for program information.**