HealthPlans, Inc.

Claim Form — Flexible Spending Account

Transportation/Parking Reimbursement

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	*First Name (Subscriber)*	*MI*	*Date of Birth*

Mailing Address	*City*	*ST*	*ZIP Code*

Email Address	*Primary Phone#*	*Alternate Phone#*

Instructions

- You may submit claims monthly, quarterly or annually. You may be reimbursed up to the maximum monthly limit (as determined annually by the IRS) for employee parking expenses, transit pass expenses 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

Dates Incurred *(MM/YYYY)*	Name/Location of Parking Garage or Lot	Total Amount of Expenses		Amount Over Monthly Limit		Requested Reimbursement
		$	*LESS*	$	=	$
		$	*LESS*	$	=	$
		$	*LESS*	$	=	$

Transit Passes & Commuter Vanpool Expenses

Dates Incurred *(MM/YYYY)*	Name of Transit System or Vanpool	Total Amount of Expenses		Amount Over Monthly Limit		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.

Signature: _____ _____

Signature of Employee *Date Signed*

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 **877-734-7004**, or submit your question online at **HealthPlansInc.com**; just click on **Contact**.*