Non-Medical Parking & Transit Claim Form

Flexible Spending Account

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100
Braintree, MA 02184
www.cpa125.com

Email: info@cpa125.com
Phone: 781-848-9848
FAX: 781-848-8477

Plan Year: _____

Name: _____ ***Employer:*** _____

Street: _____ ***SSN (Last four)*** ***XXX-XX-***

City, State, Zip: _____ ***Participant Phone:*** _____

Check if New Address ☐ ***Email:*** _____

Complete amount to be reimbursed per month. Attach proof of payment.

	Transit $	**Parking $**			**Transit $**	**Parking $**
January				July		
February				August		
March				September		
April				October		
May				November		
June				December		

- All claims require copies of bills/statements/receipts showing date and service. (IRS regulation)
- Cancelled checks/bank statement/credit card receipts are not adequate substantiation.
- Direct deposit payments are processed weekly on Wednesday and checks are mailed bi-weekly.
- Please allow 3 business days after processing date to receive your reimbursement.
- All claims must be received by Monday to be included in that week's processing.

Certification

I, the undersigned, have incurred the expenses listed above that qualify for reimbursement under my employer's cafeteria plan. I have not been, and will not be reimbursed for these expenses from any source including, but not limited to, insurance, this plan, or other programs offered by my, or my spouses, employer. I understand these expenses may no longer be claimed as deductions for income tax purposes since I am requesting reimbursement with funds deducted from my compensation on a pre-tax basis. I acknowledge I am solely liable for any taxes or penalties on ineligible expenses submitted through the medical flexible spending account. I, and only I, am responsible for the accuracy and validity of the submitted expenses and will retain substantiation. I hereby request reimbursement for these expenses, and, if applicable, reaffirm the authorization provided to Cafeteria Plan Advisors, Inc. to directly deposit the reimbursement into my bank.

Participant's Signature: _____ **Date:** _____

Attach copies of receipts and mail, fax, or scan as a PDF and email to info@cpa125.com
Retain originals for your records

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