

# Transit/Parking FSA CLAIM FORM

**Submit Claims To:**  
 Custom Design Benefits, Inc.  
 5589 Cheviot Road  
 Cincinnati, Ohio 45247  
 Ph: (800) 598-2929  
 Fax: (513) 598-2901  
[CustomFlex@CustomDesignBenefits.com](mailto:CustomFlex@CustomDesignBenefits.com)

Employer: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Employee or Social Security Number: \_\_\_\_\_

 Check here if new address Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

E-mail Address \_\_\_\_\_ Phone: \_\_\_\_\_

**TO EXPEDITE YOUR CLAIM:** Please provide appropriate information, **INCLUDING PHOTOCOPIES AND RECEIPTS**. Claims received less than 24 hours prior to the scheduled reimbursement date will be processed on the next scheduled reimbursement date.

**Qualified Parking Garage & Meter Expenses**

Date From (MM/DD/YYYY)	Date To (MM/DD/YYYY)	Amount of Reimbursement	Metered Parking? (Check one)	If no, please provide Parking Facility Name
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby certify that I have incurred the expenses indicated above and any additional burden of proof will remain my responsibility if I am required to provide substantiation.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Qualified Mass Transit & Auto Share Expenses**

Date From (MM/DD/YYYY)	Date To (MM/DD/YYYY)	Amount of Reimbursement	Bus Fare? (Check one)	If no, please provide Mass Transit or Auto Share Provider
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby certify that I have incurred the expenses indicated above and any additional burden of proof will remain my responsibility if I am required to provide substantiation.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Read Carefully:** The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the expenses have not been reimbursed or are not reimbursable under any other plan coverage. 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 relate to such expense. Please do not include original receipts since, after the claim is substantiated, Custom Design Benefits does not keep receipts on file.

 \_\_\_\_\_  
 Employee's Signature

 \_\_\_\_\_  
 Date