## **Tax-Free Transportation Program Request for Reimbursement Form**

Employer				
Name		Social Security # Pho	one #	
Address		City, State, Zip Ne	_ New address? ☐ Yes ☐ No	
Qualified Parki	NG EXPENSE			
Name of Parking Facility	Month Service Incurred	Address of Parking Facility	Amount Incurred*	
		Total Amount:		
QUALIFIED TRANS  Name of Transit	IT PASS/COMM  Month Service	UTER HIGHWAY VEHICLE EXPENSE  Expense	Amount	
Provider	Incurred	Description	Incurred*	
		Total Am	nount:	
* Monthly amount ca	annot exceed indexed	amount. Indexed amount for 2015 is \$130.00	,	
**You must attach	a receipt/statement fr	rom the parking facility or transit provider showing amo	ount and dates of service.	
were incurred during a such expenses and that near the business prem direct commute from he accuracy, and veracity which payment or rein	period while the undersignall expenses for which relises of the Employer, or ome to work and return.  of all information relative bursement is claimed is	rtifies that all expenses for which reimbursement is claimed by signed was covered under the Employer's Tax-Free Transportation Feimbursement is claimed by submission of this form were incurred in or near a location from which participant commutes to work, at The undersigned understands that he or she alone is fully responsing to this claim which is provided by the undersigned, and that a proper expense under this Program, the undersigned may be like the come tax on amounts paid from the Program which relate to such expenses.	Program with respect to d for any parking on or and/or for regular daily lible for the sufficiency, unless an expense for able for payment of all	
Signature:	Signature: Date:			

Fax: 724-458-4464, email: flexcontact@davevic.com or mail to: Davevic Benefit Consultants, Inc., 902 South Center Street P. O. Box 976, Grove City, PA 16127

Davevic Benefit Consultants, Inc.

Section 132 Transportation Plan