

Tax-Free Transportation Program Request for Reimbursement Form

Employer _____

Name _____ Social Security # _____ Phone # _____

Address _____ City, State, Zip _____ New address? Yes No

QUALIFIED PARKING EXPENSE

Name of Parking Facility	Month Service Incurred	Address of Parking Facility	Amount Incurred*
<i>Total Amount:</i>			

*Monthly amount cannot exceed indexed amount. Indexed amount for 2020 is \$270.00

QUALIFIED TRANSIT PASS/COMMUTER HIGHWAY VEHICLE EXPENSE

Name of Transit Provider	Month Service Incurred	Expense Description	Amount Incurred*
<i>Total Amount:</i>			

* Monthly amount cannot exceed indexed amount. Indexed amount for 2020 is \$270.00

****You must attach a receipt/statement from the parking facility or transit provider showing amount and dates of service.**

The undersigned participant in the Program certifies that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while the undersigned was covered under the Employer's Tax-Free Transportation Program with respect to such expenses and that all expenses for which reimbursement is claimed by submission of this form were incurred for any parking on or near the business premises of the Employer, on or near a location from which participant commutes to work, an d/or for regular daily direct commute from home to work and return. The undersigned 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 this Program, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Program which relate to such expense.

Signature: _____

Date: _____

You may copy this form if additional forms are needed.

**Fax or mail to: 724-458-4464
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P. O. Box 976, Grove City, PA 16127**