Transit/Parking Claim Form

MAIL:
PO BOX 7500
CHAMPAIGN, IL
61826-7500

FAX:
877-760-7076

PHONE:
877-272-8880

ONLINE:
www.mywealthcareonline.com/bpcinc

##11BPC001##################

Employer: _____

Participant Name (please print): _____ SSN: X X X – X X – ____

Day Time Phone Number: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ Email Address: _____

☐ I have **Changed** My Address _____
Street City State ZIP

Instructions: Complete the information below for Transportation Expenses incurred or paid by you. For information as to what Transportation Expenses can and cannot be reimbursed, see the Summary Plan Description. You must provide bills, invoices, statements, from an independent third party, parking receipts, used transit pass or other evidence showing that the Expenses were incurred or paid (cancelled checks will not be accepted). If form is incomplete, it will be returned to you.

Expense Description	Dates of Service (From—To)	Provider	Claimant	Amount of Purchase
				$
				$
				$
				$
				$
				$
			AMOUNT REQUESTED:	$

PLEASE READ CAREFULLY: To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following. I used the Transportation Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at the Employer. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Transportation Expenses under the Plan. I have not been reimbursed previously for these expenses under the Plan. These expenses have not been reimbursed or are not reimbursable under any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit, or to claim reimbursement under another plan. I authorize a deduction in my Transportation Account in the amount of the reimbursement. Signature required on all claim forms submitted.

A signature is required on each claim form that is submitted.

Participant Signature: _____ Date Submitted: _____

COMPLETE THIS SECTION ONLY IF YOU DID NOT ATTACH RECEIPTS:

Brief Reason of why proof or receipt not available:

Provider Address:

Provider Signature:	**Date:**