EMPLOYEES Benefits Council

MONTHLY MASS TRANSPORTATION EXPENSE REIMBURSEMENT CLAIM FORM

Name of Employee (Last, First, M.I.) _____

Daytime Phone Number _____

☐ Address (Check box if new Address) _____

Employee ID or Social Security Number (Required) _____

City & State _____ Zip Code _____

Agency Name and Number _____

Date(s) of Expense	Name of Service Provider	Amount of Monthly Expense
		$
		$
		$
		$
	Total Requested	$

I HEREBY CERTIFY that the expense(s) shown has(have) actually been incurred as an eligible plan expense(s) during the eligible date above for **MYSELF**; and that this expense(s) has(have) not been, and I will not seek to be paid or reimbursed from any other source, be deducted or used to calculate a tax credit on any tax return or has been previously submitted for reimbursement under this or any other plan. I understand that any amounts not used for qualified expenses by the end of the Plan Year will be forfeited to the plan per IRS Regulations. I also understand there is a monthly maximum allowed to be reimbursed per IRS Rules.

_____ _____

SIGNATURE OF EMPLOYEE REQUIRED Date signed

Mail to: Employees Benefits Council
PO Box 24087
Oklahoma City, OK 73124-0087
405-232-1190 in OKC or 1-800-219-8115 x301 in Oklahoma

Claims must be received or US Postmarked by March 31.

Print Form Reset Form