

ASSOCIATED UNIVERSITIES, INC. COMMUTER & PARKING BENEFIT REIMBURSEMENT PROGRAM Claim Form

INSTRUCTIONS

- A complete claim form must be included with each submission for reimbursement.
- Sign and date the claim form in the area provided. Electronic signatures are acceptable.
- Attach a copy of van pool, parking, or transit passes, bills, receipts, etc. showing the date the expense was incurred for which you are requesting reimbursement.
- Receipts/proof of payment will not be returned to you copies can be sent, or make copies for your records.
- Payment will not exceed the amount of accumulated funds in your account.
- Payment will not exceed the maximum monthly benefit amount (IRS determined).
- Claim forms must be sent to the Benefits Office in Charlottesville. Faxed, mailed or emailed copies are acceptable, as long as they are legible.

CLAIM INFORMATION			
EMPLOYEE NAME:	First		M.I.
EMPLOYEE #:			
WORK ADDRESS:			
I request reimbursement for the following commuter expenses. I certify I have incurred these expenses and that the information provided is true and correct.			
Transit services:	\$ for servi <i>Max \$270 per month</i>	ces during Month	, Year
Parking expense:	\$ for servi <i>Max \$270 per month</i>	ces during Month	, Year
Signature	Emj	oloyee #	Date
OFFICE USE ONLY			
Amount Approved for paymen	t:		
Authorized H.R. Representativ	/e:	Date: _	
			01/2020