

**State of Connecticut
Qualified Transportation Account
Claim Reimbursement Form
Revised 10/10**



EMPLOYEE NAME		SOCIAL SECURITY NUMBER	EMPLOYEE NUMBER	DATE OF BIRTH
HOME ADDRESS (<input type="checkbox"/> Check if new address)			CITY, STATE, ZIP CODE	
EMAIL ADDRESS (if not on file)				
CLAIM REIMBURSEMENT INFORMATION				
DATES OF SERVICE MM/DD/YY	EXPENSE TYPE	TRANSPORTATION OR PARKING COMPANY NAME & ADDRESS		CLAIM AMOUNT
				\$
				\$
				\$
				\$
				\$
				\$
TOTAL:				\$

I certify that the expenses for reimbursement requested from my accounts were incurred by me, were not reimbursed by any other plan and to the best of my knowledge and belief are eligible for reimbursement under my Qualified Transportation Account. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

This reimbursement is exclusively for the cost of my regular daily direct commute from home to work and return in a Public Transportation Vehicle or for the regular daily cost of parking on or near my work location as allowed under IRS Code Section 132 as amended.

I have not given, bartered, exchanged, conveyed or otherwise transferred this benefit to any other person.

I understand that the claim submission deadline is 180 days from the date the expense is incurred.

I acknowledge that I have read and understand the instructions, terms and conditions mentioned on this form and that my participation in the Qualified Transportation Account is in accordance with current plan provisions and Internal Revenue Code requirements.

Employee Signature _____

Date _____

Claim Submission Substantiation:

1. Attach valid receipts for each transportation and parking expense incurred to this form.
2. Make copies for your records.
3. Note: Unless a change has occurred, SSN, address, daytime phone number and email address need only be provided at initial claim submission; thereafter your name & employee number will be sufficient.

KEEP A COPY FOR YOUR RECORDS