BENEFIThelp Solutions

Commuter Expense
Reimbursement Account Claim Form

Fax: 1-888-249-5058
Submit online at www.benefithelpsolutions.com
Ph: 503-219-3679 or 1-888-398-8057
PO Box 67230 • Portland, OR 97268

DO NOT USE A FAX COVER SHEET

ACCOUNT HOLDER INFORMATION

Member ID: _____ **Phone #:** _____

Member ID or last four digits of Social Security Number (not required)

Name: _____

Last _____ First _____ New Address? _____

Address: _____

Street _____ Apt. _____

City _____ State _____ Zip _____

Email Address: _____

Employer Name: _____ **Group #:** _____

CLAIMS FOR OUT-OF-POCKET EXPENSES

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

	CERA Account	Service Start Date (MM/DD/YY)	Service End Date (MM/DD/YY)	Parking/Transit Provider	Amount Requested
1	☐ Parking ☐ Mass Transit				$
2	☐ Parking ☐ Mass Transit				$
3	☐ Parking ☐ Mass Transit				$
4	☐ Parking ☐ Mass Transit				$
5	☐ Parking ☐ Mass Transit				$

MORE EXPENSES? Complete another form.

$ 0.00
TOTAL THIS FORM

You must submit your request for reimbursement within 180 days following the date, on which the qualified transportation expense was incurred or paid, not to exceed the plan's run-out period.

To submit qualified transportation expenses, you must attach bills, invoices, statements from an independent third party, parking receipts, used transit passes or other evidence of payment showing the amounts of such qualified transportation expenses.

I request reimbursement for the qualified transportation expenses amounts itemized above. To the best of my knowledge, my statements in this Commuter Expense Reimbursement Account (CERA) Claim Form are complete and true. I certify these expenses are not covered or reimbursable from any other source, nor will I seek reimbursement for these expenses from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and cannot be used as tax deductions when filing income tax returns. I further certify that I incurred or paid these expenses as an employee of the employer named above.

Account Holder Signature: _____ **Date:** _____ **Total Number of Pages:** _____

Signature of spouse or dependents is not acceptable.

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Member ID: _____ **Phone #:** _____

Member ID or last four digits of Social Security Number (not required)

Name: _____

Last First

CLAIMS FOR OUT-OF-POCKET EXPENSES **INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED**

CERA Account	Service Start Date (MM/DD/YY)	Service End Date (MM/DD/YY)	Parking/Transit Provider	Amount Requested
6 ☐ Parking ☐ Mass Transit				$
7 ☐ Parking ☐ Mass Transit				$
8 ☐ Parking ☐ Mass Transit				$
9 ☐ Parking ☐ Mass Transit				$
10 ☐ Parking ☐ Mass Transit				$
11 ☐ Parking ☐ Mass Transit				$
12 ☐ Parking ☐ Mass Transit				$
13 ☐ Parking ☐ Mass Transit				$
14 ☐ Parking ☐ Mass Transit				$
15 ☐ Parking ☐ Mass Transit				$
16 ☐ Parking ☐ Mass Transit				$
17 ☐ Parking ☐ Mass Transit				$
18 ☐ Parking ☐ Mass Transit				$
19 ☐ Parking ☐ Mass Transit				$
20 ☐ Parking ☐ Mass Transit				$

$ 0.00

TOTAL THIS FORM