



Mail or Fax to: WCA 444 West C Street, Suite 350, San Diego, CA 92101-3533, Fax (619) 232-4440 Toll-Free Fax (866) 620-6807

TRANSPORTATION REIMBURSEMENT ACCOUNT CLAIM FORM

Employer: _____

Name: _____ Last Four Digits of Social Security #: _____

Parking Account

Start Date	End Date	Receipt (YES or NO)	Cost	Parking Provider
Total Parking Account Request			\$	

Mass Transit Account

Start Date	End Date	Receipt (YES or NO)	Cost	Mass Transit Provider
Total Mass Transit Account Request			\$	

READ CAREFULLY:

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses, and that these expenses have not been reimbursed or are not reimbursable under this plan or by any other source and that they will not be reimbursed by any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature

Date

Expense Certification: I hereby certify that for each expense listed above, for which I have not attached documentation verifying the expense, that a receipt, bill or documentation was not available as part of the normal business transaction from the provider of the service. (2nd signature required below)

Employee's Signature

Date