



Employer Name: \_\_\_\_\_

### Mass Transit Reimbursement Account Claim Form

#### PART 1 COMPLETE FOR ALL CLAIMS

Social Security Number	Last Name	First Name	M.I.
Address (Complete only if Changed)		Phone Number	
City	State	Zip Code	
EMAIL Address (Complete only if Changed)			

#### PART 2 COMPLETE FOR MASS TRANSIT REIMBURSEMENT ACCOUNT

**IMPORTANT INSTRUCTIONS:** Complete the information below for Transportation Expenses incurred or paid by you. You must provide bills, invoices, statements from an independent third party, used transit passes or other evidence showing that the Expenses were incurred or paid (canceled checks will not be accepted). Be sure to provide all information requested by this Form. If the Form is incomplete, it will be returned to you for completion and will delay payment. Please date and sign the Form, then send it along with your supporting documentation to Tri-Star at the address below.

PLEASE CHECK THIS BOX IF THIS CLAIM IS SUBSTANTIATION OF A PREVIOUS DEBIT CARD TRANSACTION

Date Paid	Period Covered	Mass Transit Provider	Amount Claimed	<input type="checkbox"/>
____/____/____	____/____/____ - ____/____/____	_____	\$ _____	<input type="checkbox"/>
____/____/____	____/____/____ - ____/____/____	_____	\$ _____	<input type="checkbox"/>
____/____/____	____/____/____ - ____/____/____	_____	\$ _____	<input type="checkbox"/>
____/____/____	____/____/____ - ____/____/____	_____	\$ _____	<input type="checkbox"/>

#### PART 3 ACKNOWLEDGMENT AND SIGNATURE

To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following: I used the Transportation Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at my Employer. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Transportation Expenses under the Plan. I have not been reimbursed previously for these expenses under the Plan. These expenses have not been reimbursed or are not reimbursable under any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit, or to claim reimbursement under another plan. I authorize a deduction in my Transportation Account in the amount of the reimbursement.

Employee Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

FAX or mail signed and dated form with supporting documentation to:

<b>Tri-Star Systems</b>	<b>(314) 576-4022</b>	<b>Phone</b>
<b>Attn: Claims Dept.</b>	<b>(800) 727-0182</b>	<b>Toll Free</b>
<b>14323 South Outer 40 Road, Suite 200 South</b>	<b>(314) 985-0277</b>	<b>Claims Only Fax</b>
<b>Chesterfield, MO 63017-5734</b>		
Hours:	Monday – Thursday: 7am – 5pm CST	Friday 8am – noon CST