

Transportation Reimbursement Claim Form



Employer Name:	CITY OF ST PAUL	Plan Year: 01/01/2016 to 12/31/2016
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Employee Information

Last Name	First Name	Employee ID		
Street 1				
Street 2		City	State	Zip Code
Work Phone	Home Phone	E-mail		

Claim Information

<u>Parking Fee Request</u> These services MUST have been incurred during the current plan year as shown on the top of this form.	Date And Type Of Services Incurred And Cost				
		Date	Type	For the Month(s) Of	Cost
	1.				\$
	2.				\$
	3.				\$
	4.				\$
	5.				\$
(Monthly Parking Maximum \$250.00)				TOTAL	\$

Signature

I request payment from my Transportation Reimbursement Account for the expenses listed. To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. I am claiming reimbursement only for eligible expenses incurred during the plan year. I certify that these expenses have not and will not be reimbursed under any other benefit plan and will not be claimed as an income tax deduction. I authorize my Transportation Reimbursement Account to reimburse me by the amount requested.

Participant's Signature	Date
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Send completed claim form and all documentation to:	CieloStar Attn: Flexible Spending Dept. 730 2 nd Avenue South, Suite 530 Minneapolis, MN 55402	Fax or email claims to: (877) 491-6016 (Toll Free) (612) 335-9217 (Local) flex@cielostar.com
For questions regarding your account or claim status, contact:		(877) 491-5979 flex@cielostar.com

Claims are processed each business day.