



COMMUTER BENEFIT ACCOUNT (CBA) REIMBURSEMENT REQUEST FORM

EMPLOYER NAME _____ PLAN YEAR _____

PLEASE PRINT OR TYPE (USE ADDITIONAL SHEETS IF NECESSARY)

NOTE: THIS FORM CAN ONLY BE USED FOR SERVICES INCURRED DURING THE PLAN YEAR SHOWN ABOVE				____ - ____ - ____ <small>SOCIAL SECURITY NUMBER</small>
EMPLOYEE NAME _____				
<small>LAST</small> _____	<small>FIRST</small> _____	<small>MI</small> _____	DAY PHONE (____) _____	
EMPLOYEE HOME ADDRESS _____			EMPLOYEE E-MAIL ADDRESS _____	
<small>NUMBER AND STREET</small> _____	<small>CITY</small> _____	<small>STATE</small> _____	<small>ZIP CODE</small> _____	
EMPLOYER WORKSITE LOCATION _____				CHECK HERE IF THIS IS A CHANGE IN ADDRESS <input type="checkbox"/>

INSTRUCTIONS
 Complete the information below for Transportation Expenses incurred or paid by you. (For information as to what Transportation Expenses can and cannot be reimbursed, see the Summary Plan Description.) You **MUST** provide bills, invoices, statements from an independent third party, parking receipts, 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 on this form. If the form is incomplete, it will be returned to you. Please sign and date the form and send it along with your supporting documentation to Medical Group Insurance Services, Inc. at the address below.

	EXAMPLE	EXPENSE #1	EXPENSE #2	EXPENSE #3	EXPENSE #4
DATE(S) TRANSPORTATION SERVICE PROVIDED OR PAID	10/01/05–10/31/05				
TYPE OF TRANSPORTATION EXPENSE <small>(Transit Pass, Commuter Highway Vehicle, Qualified Parking)</small>	TRANSIT PASS				
PROOF OF EXPENSE ATTACHED? <small>(If not, explain why proof not available in ordinary course of business)</small>	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
TOTAL EXPENSE	\$90	\$	\$	\$	\$
REIMBURSEMENT AMOUNT REQUESTED	\$90	\$	\$	\$	\$
TOTAL REIMBURSEMENT AMOUNT REQUESTED					\$

To the best of my knowledge and belief, my statements on this Request for Reimbursement 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 the 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 hereby authorize my Transportation Account to be reduced by the amount(s) shown above.

PARTICIPANT'S SIGNATURE X	DATE
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FAX COMPLETED FORM AND ALL DOCUMENTATION TO: **MEDICAL GROUP INSURANCE SERVICES, INC.**
 CLAIMS FAX: 801.990.0212

If you have questions or need assistance, call 1.866.937.3539 or go to www.We-R-CDH.com.

FOR OFFICE USE ONLY

ACCOUNT BALANCE PRIOR TO THIS CLAIM	AMOUNT APPROVED THIS CLAIM	DATE APPROVED	APPROVED BY	BALANCE FORWARD

COMMENTS _____