Qualified Transportation Account
Claim Reimbursement Form

CO-1313 Revised 9/2018

Office of the State Comptroller
Healthcare Policy & Benefit Services Division

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	EMPLOYEE NUMBER	DATE OF BIRTH
	- -		/ /

HOME ADDRESS	EMAIL ADDRESS (if not on file)
(☐ Check if new address)	

CLAIM REIMBURSEMENT INFORMATION

DATES OF SERVICE MM/DD/YY	EXPENSE TYPE	TRANSPORTATION OR PARKING COMPANY NAME & ADDRESS	CLAIM AMOUNT
			$
			$
			$
			$
			$
			$
		TOTAL:	$

I certify that the expenses for reimbursement requested from my accounts were incurred by me, were not reimbursed by any other plan and to the best of my knowledge and belief are eligible for reimbursement under my Qualified Transportation Account. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

This reimbursement is exclusively for the cost of my regular daily direct commute from home to work and return in a Public Transportation Vehicle or for the regular daily cost of parking on or near my work location as allowed under IRS Code Section 132 as amended.

I have not given, bartered, exchanged, conveyed or otherwise transferred this benefit to any other person.

I understand that the claim submission deadline is 180 days from the date the expense is incurred.

I acknowledge that I have read and understand the instructions, terms and conditions mentioned on this form and that my participation in the Qualified Transportation Account is in accordance with current plan provisions and Internal Revenue Code requirements.

Employee Signature _____ Date _____

Claim Submission Substantiation:

1. Attach valid receipts for each transportation and parking expense incurred to this form.
2. Make copies for your records.
3. Note: Unless a change has occurred, SSN, address, daytime phone number and email address need only be provided at initial claim submission; thereafter your name & employee number will be sufficient.

KEEP A COPY FOR YOUR RECORDS

MAIL OR FAX COMPLETED FORM TO: Progressive Benefit Solutions, LLC (PBS), 14 Business Park Drive #8, Branford, CT 06405
Claims FAX: (203) 974-4890 Phone: 1-866-906-8023 Local # (203) 985-1712