PROGRESSIVE BENEFIT SOLUTIONS, LLC

Request for Reimbursement

MASS TRANSIT/PARKING CLAIM FORM (01/2009)

Employer Name: _____

Employee Name:	Last First MI	**SS#**	
Address:	Street City State ZIP	**Phone:**	( )

~ **Please check if this is a new address**

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim.

* Information below must be completed

QUALIFIED MASS TRANSIT CLAIMS

Date of Service MM/DD/YY	Patient Name	Patient's SS#	Relationship	Name of Provider	Description of Service	Claim Amount
						$
						$
						$
						$
						$
						$
						$
						$
$						

QUALIFIED PARKING CLAIMS

Date of Service From	To	Form of Transportation	Provider Name		Provider Address		Claim Amount
							$
							$
							$
							$
$							

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.
Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature:_____ **Date:** _____ /_____ /_____

FOR FASTEST REIMBURSEMENT, FAX TO 203-234-1139

OR MAIL TO: PROGRESSIVE BENEFIT SOLUTIONS, LLC 23 MAIDEN LANE, NORTH HAVEN, CT 06473