Transportation/Parking Reimbursement Request Form

Allegiance℠ by Cigna Healthcare

Complete the information below for Transportation or Parking Expenses incurred or paid by you. (For information as to what Transportation or Parking Expenses can and cannot be reimbursed, see the Summary Plan Description.)

Instructions

1. Complete all sections of this form.
2. Provide bills, invoices, statements from an independent third party, parking receipts, used transit passes, or any other evidence showing that the expenses were incurred or paid (**Please Note:** Cancelled checks will not be accepted).
3. Securely email, mail, or fax **completed** form and documentation to:
   Secure Email: Allegianceform@healthaccountservices.com
   Address: P.O. Box 2396 Fargo, ND 58108-2396
   Fax: (833) 480-7005

   Please Note: If the form is incomplete, your claim will be denied.
4. If you have any questions about completing this form, please contact Allegiance Advantage Consumer Services at (877) 424-3570. We have representatives available Monday-Friday, 7:00 am to 7:00 pm CST.

Step 1: Consumer Information

*Required Fields

*Consumer Name (First, MI, Last)

*Employer Name

*Birth Date (MM/DD/YYYY)

*Social Security Number

*Phone Number

*Permanent Address

Email Address

*City

*State

*Zip Code

Step 2: Reimbursement Information

According to IRS Code §132, cash reimbursement for transit passes is only permitted "if a voucher/debit card or similar item which may be exchanged only for a transit pass is not readily available for direct distribution by the employer to the employee."

Please indicate why a voucher/debit card or similar item was not able to be used.

*Explanation

*Date(s) Service Provided:[1]	*Type of Expense (Transportation or Parking)	*Have you attached proof of the expense? If no, explain why proof is not available in ordinary course of business.	*Reimbursement Amount Requested
		☐ **Yes** ☐ **No, please explain:**	$
		☐ **Yes** ☐ **No, please explain:**	$
		☐ **Yes** ☐ **No, please explain:**	$
		Total Amount Requested:	$

[1] The date range cannot exceed one calendar month. Please enter each month on a separate line.
You must submit claims for Reimbursement within 180 days after you incur a Transit or Parking Expense.

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Step 3: Consumer Certification

To the best of my knowledge and belief, my statements in this Form are complete and true. I certify to all of the following. I used the Transportation or Parking Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at the Company. I understand that requests related to transit expenses are only eligible for cash reimbursement if a voucher or similar item which may be exchanged only for a transit pass is not readily available and if applicable, by submitting this request, I certify that to be the case in this instance. 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. I understand that requests related to transit expenses are only eligible for cash reimbursement if a voucher or similar item which may be exchanged only for a transit pass is not readily available and by submitting this request, I certify that to be the case with this claim. 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. I acknowledge that this form may be electronically signed via a digitized version of my written signature or with a digital certification using my full name. I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

*Consumer Signature

*Date