take care®
by WageWorks

COMMUTER BENEFIT ACCOUNT
PAY ME BACK CLAIM FORM

TOLL-FREE FAX: 877-782-8889
Email: claims@takecareclaims.com
Or mail to take care by WageWorks, PO Box 14054, Lexington, KY 40512

To ensure speedy processing:
DO NOT USE A FAX COVER SHEET

ACCOUNT HOLDER INFORMATION

Last Name

First Name

Social Security Number

Employer / Program Sponsor's Name

Zip Code

Birth Month/Day (MM/DD)

Email Address (complete only if new)

CERTIFICATION AND AUTHORIZATION

The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Employer's Commuter Benefit Program with respect to such expenses and that all expenses for which reimbursement is claimed by submission of this form were incurred for any parking on or near the business premises of the Employer, on or near a location from which participant commutes to work, and/or for regular daily direct commute from home to work and return and that the expenses have not been reimbursed and that the participant will not seek reimbursement from any other plan for these services. The undersigned understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under this Program, the undersigned may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Program which relate to such expense.

Employee's Signature

Date

QUALIFIED PARKING EXPENSE

Name of Parking Facility	Month Service Incurred	Address of Parking Facility	Amount Incurred*
		Total Parking Expense Claim	

* Monthly amount cannot exceed 2014 indexed amount of $250 per month.

QUALIFIED TRANSIT PASS/COMMUTER HIGHWAY VEHICLE EXPENSE

Name of Transit Provider	Month Service Incurred	Expense Description	Amount Incurred**
		Total Transit/Commuter Expense Claim	

** Monthly amount cannot exceed 2014 indexed amount of $130 per month.

To complete an electronic claim form or check your account balance go to **takecareWageWorks.com**

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Claim Form & Filing Instructions

On the reverse side of this page is a claim form. Please feel free to copy this form.

Please be sure to number each attachment page (e.g., Page 2 of 3, Page 3 of 3, etc.).

- Fax: For faster service, fax your claim to 877-782-8889. Your claim form is your fax cover page. After you fax a claim, please do not follow up with a postal mail or email.
- Email: For even faster service, scan your claim form with receipts into a single PDF. Your claim form should be the first page of your scan. Email the PDF to claims@takecareclaims.com. After you email a claim, please do not follow up with a postal mail or fax.
- Postal Mail: If you don't use email or fax, postal mail your claim to take care by WageWorks, PO Box 14054, Lexington, KY 40512.

Remember to keep the original claim form for your records.

To verify your claim has been received, go to the website described below. When your claim is approved, it will appear within three business days on the website under "View Account."

You may check your account balance status any time, day or night at the website. In addition, the website has a claim form, a list of qualifying expenses, and other administrative tools that will help you conveniently manage your account. The site also has frequently asked questions and instructions on how to contact us.

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takecareWageWorks.com

Everything you need to manage your Flexible Benefit Account:

- Verify your election
- View your account balance
- Complete electronic claim form
- How and where to file claims
- Look up qualified expenses
- Change in status rules
- Eligibility requirements
- Learn about the plan
- How to contact us

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Copy the front and back of this claim form for future use.