I.F. IntegraFlex
An Industry Leader in Consumer-Driven Healthcare Solutions

Commuter Reimbursement Claim Instructions

Important: Estimates for services that have not yet been incurred ***cannot*** be accepted. Be sure to keep a copy of your documentation on file at all times.

Documentation Instructions:

IRS acceptable supporting documentation for **Qualified Parking Expense**:

- Itemized Billing Statement showing the following detail:
  1. Name of Parking Facility
  2. Address of Parking Facility
  3. Month Service was Incurred
  4. Monthly Amount Incurred

IRS acceptable supporting documentation for **Qualified Transit Pass/Commuter Highway Vehicle Expense**:

- Itemized Billing Statement showing the following detail:
  1. Name of Transit Provider
  2. Description of Expense
  3. Month Service was Incurred
  4. Monthly Amount Incurred

Claim submission methods: Upload, fax or email your completed contract to IntegraFlex

- Sign In to the IntegraFlex Employee Portal – https://integraflex.wealthcareportal.com to upload your Dependent Care Claim Form with your supporting documentation.
- Fax to: (855) 673-6711
- Email to: claims@integra-flex.com

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COMMUTER BENEFIT ACCOUNT
Claim Form

Claim Filing Options:

- **Fax:** 855-673-6711
- **Email:** claims@integra-flex.com
- **IntegraFlex Employee Portal:** https://integraflex.wealthcareportal.com

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

ACCOUNT HOLDER INFORMATION

Last Name | First Name

Last 4 of your SSN | 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*
*Monthly amount cannot exceed 2018 indexed amount of $260 per month.		TOTAL PARKING EXPENSE CLAIM	0

QUALIFIED TRANSIT PASS/COMMUTER HIGHWAY VEHICLE EXPENSE

NAME OF TRANSIT PROVIDER	MONTH SERVICE INCURRED	EXPENSE DESCRIPTION	AMOUNT INCURRED**
**Monthly amount cannot exceed 2018 indexed amount of $260 per month.		TOTAL TRANSIT/COMMUTER EXPENSE CLAIM	0

To check your account balance, please visit https://integraflex.wealthcareportal.com.