



Employee Data

Company Name:

Employee Name:

Employee ID (Last 4 of SSN):

Reimbursement Request

Date of Service	Name of Parking Provider	Amount of Claim
		\$
		\$
		\$
		\$
		\$
		\$

Verification

To the best of my knowledge and belief, the statements in this Vita Flex parking expense claim form are complete and true. I certify these claims are for parking expenses either on or near my Employer's business premises or on or near a location from which I commute to work (e.g. mass transit, commercial commuter highway vehicle, qualifying non-commercial commuter highway vehicle or carpool). *Additionally, I will not submit these expenses for reimbursement under any insurance plan or from any other source.* I understand that these expenses may not be used to claim any federal income tax deduction or credit. I understand that I alone am responsible for the sufficiency, accuracy and validity of all information relating to this claim. If any claim for reimbursement is not an eligible expense under the plan, I will be responsible for payment of all related liabilities, including federal and state income taxes and any applicable penalties resulting from improper reimbursement from the plan.

Date

Employee Signature

New Phone/Address (Complete Only if Needed)

New Email Address:

New Home Address:

Online:

www.vitaflex.net

Fax:

Vita Flex Claims Dept.
(650) 964-FLEX (3539)
(866) 964-FLEX (3539)

E-mail:

claims@vitamail.com

Mail:

Vita Flex Claims Dept.
900 North Shoreline Blvd.
Mountain View, CA 94043