Commuter Cash Back Form

Use this form to request reimbursement from your applicable commuter account.

INSTRUCTIONS

1. **Fill** in all requested information and **attach** all supporting documentation if applicable
2. **If you are unable to attach your form or document to an online or mobile app claim or alert**, you may use one of these secondary options to send your documentation to us. Please note, that Igoe cannot guarantee the security of any documentation provided to use via the below methods while in transit to our organization:
   - Email to claims@goigoe.com
   - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
   - Expenses MUST be listed according to the calendar month in which the expense took place.
3. **Tips**
   - Please allow up to 4 business days for your completed request to be updated online.
   - Receipts are required in order to receive reimbursement when receipts are available to you. Please make every attempt to get a receipt when using qualified commuter related services. Original copies should be retained for your personal records.

   Questions? Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You (All information is REQUIRED. Please print clearly)

Employer Name

Participant Name	Number of pages	Employee Number (If Applicable)	
Home Address ☐ Please check if this is a change in address	City	State	Zip
E-mail Address		Phone Number	

Section B: Commuter Expense Incurred

Dates Covered	Description of Expense (Transit or Parking)	Net Amount
-		$
-		$
-		$
-		$
-		$
	Total Commuter Expenses	**$** 0.00

Section D: Authorization *REQUIRED (PLEASE SIGN AND DATE)

I certify that I am a participant in the plan from which I am requesting reimbursement and that all expenses listed with this claim were incurred during my active participation in said plan. I certify that these expenses have not been and will not be reimbursed under any other benefit plan or charged to my employer's Benefits Card (if applicable). I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information herein. I further acknowledge that each expense listed above must be a proper expense under the Plan. If not, I understand that I may be liable for the payment of all related taxes including Federal, State or City Income Tax on amounts reimbursed. I further understand that NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE. If this claim is associated with a reimbursement from a Qualified Transit Account, I attest that I was unable to use my Benefits Card as required due to one of the following reasons: (1) I do not have my Benefits Card yet (2) My Benefits Card was reported lost or stolen (3) the merchant was unable to successfully use my Benefits Card at that time that I made the purchase associated with this claim. Having agreed to all of the proceeding statements, I authorize the account associated with the plan selected to be reduced by the amount requested and reimbursed to me according to my employer's reimbursement schedule and method.

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

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