LIFE TIME℠
THE HEALTHY WAY OF LIFE COMPANY

HEALTHEZ®

# Transit & Parking Expenses Reimbursement Form

| First Name: | MI: | Last Name: | |
|---|---|---|---|
| Social Security Number or Member ID: | | Date of Birth: | |
| Address | City: | State: | Zip code: |
| Phone Number | Email: | | |

(For notification that form was received)

## Transit/Van Pooling Reimbursements:

**Please attach documentation or a receipt to substantiate the expenses you are claiming. The receipt or documentation must include the transit authority name, the date of transportation, and the dollar amount paid. If receipts are not provided in the ordinary course of business please explain below.**

| | Date of Transportation: | | Service Provider: | Dollar Amount: |
|---|---|---|---|---|
| | Start Date: | End Date: | | |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| | | | Total Unreimbursed Transit Expenses: | $ |

## Parking Reimbursements:

**Please attach documentation or a receipt to substantiate the expenses you are claiming. The receipt or documentation must include the parking facility name, the date range of parking, and the dollar amount paid. If receipts are not provided in the ordinary course of business please explain below.**

| | Date of Parking: | | Service Provider: | Dollar Amount: |
|---|---|---|---|---|
| | Start Date: | End Date: | | |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| | | | Total Unreimbursed Parking Expenses: | $ |

☐ **Check here if you are not already setup with Direct Deposit for your reimbursements, but would like to be. Attach voided check for your reimbursements to be directly deposited into your account.**

### Read Carefully

The undersigned participant in the plan certifies that all expenses for which reimbursement of payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the company's cafeteria plan. The undersigned fully understands that he/she alone is 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 of reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related federal, state, or city income tax on amounts paid from the plan which relate to such expense.

Employee Signature: Date:

This form may be emailed to service@healthez.com, faxed to **952-896-0372**, submitted through your personal online account, or mailed to: **HealthEZ, Eligibility Department, 7201 W 78th St Bloomington, MN 55439**. For assistance, call the number on the back of your health plan ID card.