

TOLL-FREE FAX: 877-782-8889

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)
	E-mail 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 Tax-Free Transportation 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. 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			

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 indexed amount. Indexed amount for 2009 is \$120 per month (January 1, 2009 through February 28, 2009). This amount increases to \$230 per month on March 1, 2009.

To complete an electronic claim form
or check your account balance go to

takecareWageWorks.com

take care[®] COMMUTER BENEFIT ACCOUNT

Claim Form & Filing Instructions

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

When filing your claim, you must attach copies of the receipts. *The receipt must show the date and type of service for the expense.* Canceled checks, credit card slips, or statements showing only a balance due on your account are not allowable.

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

- **Postal Mail:** If you choose to mail your claim with receipts, the address is take care by WageWorks, PO Box 14054, Lexington, KY 40512.
- **Fax:** If you choose to fax your claim with receipts, the fax number is 877-782-8889. After you fax a claim and receipts, please *do not* follow up with a hard copy in the mail.

Remember to keep the original claim form and supporting documents for your records.

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

You may check your account balance status any time, day or night at the web site. In addition, the web site 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.

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

take care[®]
by WageWorks

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