RESET FORM

PARKING REIMBURSEMENT REQUEST

Voya Benefits Company, LLC
A member of the Voya® family of companies
Customer Service: Health Account Solutions, PO Box 1168, Minneapolis, MN 55440
Phone: 833-232-4673; Fax: 855-370-0670; Email: HASInfo@voya.com

Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by Voya Institutional Trust Company.

Complete the information below for Parking Expenses incurred or paid by you. (For information as to what Parking Expenses can and cannot be reimbursed, see the Summary Plan Description.) Be sure to provide all information requested by this form. **If the form is incomplete, your claim will be denied.**

STEP 1: ACCOUNT HOLDER INFORMATION

Consumer Name *(Required) (First)* _____ *(Last)* _____

Employer Name *(Required)* _____

Birth Date *(mm/dd/yyyy) (Required)* _____ Social Security Number (SSN) *(Required) (Last 4 digits only.)* _____

Daytime Phone *(Required)* _____ Email _____

Permanent Address *(Required)* _____

City _____ State _____ ZIP _____

STEP 2: REIMBURSEMENT INFORMATION

Date(s) Service Provided [1] *(Required)*:	Reimbursement Amount Requested *(Required)*	Date(s) Service Provided [1] *(Required)*:	Reimbursement Amount Requested *(Required)*
	$		$
	$		$
	$		$

Total Amount Requested $ 0.00

[1] *The date range cannot exceed one calendar month. Enter each month on a separate line.*

STEP 3: PARTICIPANT CERTIFICATION

To the best of my knowledge and belief, my statements in this request are complete and true. I certify all of the following: I used the Parking Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at the Company; I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Parking Expenses under the Plan; I have not been reimbursed previously for these expenses under the Plan; These expenses have not been reimbursed or are not reimbursable under any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit or to claim reimbursement under another plan. I authorize a deduction in my Parking Account in the amount of the reimbursement.

Participant Signature *(Required)* _____ Date *(Required)* _____

Mail or fax the completed form and supporting documentation to:
Voya Financial, Health Account Solutions, PO Box 1168, Minneapolis, MN 55440; Fax: 855-370-0670.
Questions? Call Customer Service at 833-232-4673 (Live customer support 24x7).