BANK OF AMERICA

HEALTH & BENEFIT ACCOUNTS

Parking reimbursement request form

Instructions: Please complete the information below for parking expenses incurred or paid by you. Please ensure all information is provided on this form. Incomplete forms will be denied. This form cannot be used to submit a reimbursement claim for transit expenses. Transit expenses can only be paid using your debit card.

Note: You may need to provide bills, invoices, receipts, statements or any other evidence showing that the expenses were incurred or paid. Canceled checks cannot be accepted.

Please mail or fax the completed form to:

Bank of America
c/o Health Account Services
PO Box 2203
Fargo, ND 58108

Fax: 844.590.0919

We're here to help you 24 hours a day, 7 days a week.

Customer Care Center:

800.718.6710

Online Chat:

myhealth.bankofamerica.com

All fields are required.

Step 1: Accountholder information

Consumer name (First, middle initial, last)

Employer name

Birth date (MM/DD/YYYY)

Social Security number

Day telephone number

Street address

Email address

City

State

Zip code

Continued on next page.

Step 2: Reimbursement information

Date(s) service provided[1]	Type of expense	Merchant Name	**Have you attached proof of the expense?** *If no, explain why proof is not available in ordinary course of business.*	Reimbursement amount requested
			☐ Yes ☐ No, please explain:	$
			☐ Yes ☐ No, please explain:	$
			☐ Yes ☐ No, please explain:	$
			☐ Yes ☐ No, please explain:	$
			☐ Yes ☐ No, please explain:	$
			Total amount requested:	$

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

Step 3: Participant certification

I certify the following with respect to the expenses for which I am submitting a reimbursement request: (i) the expenses are the type of expenses that are eligible for reimbursement as defined by the terms of the applicable plan and the Internal Revenue Code section governing that plan; (ii) the expenses were incurred by an eligible person(s) as defined by the terms of the Plan and the Internal Revenue Code section governing the plan; (iii) the expenses have not been previously reimbursed from any other source (including the plan) and reimbursement will not be sought for such expenses from another source; and (iv) the information I provided with my reimbursement request is complete and accurate. I understand that the employer, the plan, and Bank of America, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. If there are any changes in the provided information, I understand it is my responsibility to promptly notify Bank of America. I understand that I should retain a copy of the substantiation submitted with my request in the event of an IRS audit.

Participant signature

Date (MM/DD/YYYY)

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