

COMMUTER PLAN CLAIMS

CONTACT INFORMATION

Benefits Department

Phone: (925) 956-0514

Fax: (866) 320-1931

Email: benefits@pensiondynamics.com

Address: 2300 Contra Costa Blvd., Suite 400
Pleasant Hill, CA 94523

Website: www.pensiondynamics.com

Customer Service

The best way to check your claim status is to log into your account online at www.pensiondynamics.com. If you have not yet registered for an account, please contact Pension Dynamics Company LLC. The website is available 24/7 and is a great resource once you have registered.

Customer Service is available at (925) 956-0514 from 8 AM - 5 PM PST, Monday - Friday. You can also email us at benefits@pensiondynamics.com. Please include your name and your employer name on any correspondence sent to us but do not include confidential information such as your Social Security Number.

Important information before you begin

Tips for Completing the Claim Form

- Fill out each section completely. Any incomplete forms will not be able to be processed.
- Type or write legibly.
- Don't forget to sign your form. The employee who is participating in the plan is required to sign the form, not your spouse or other dependent.
- Expenses can only be incurred by the employee, not your spouse or other tax dependent.
- This is a monthly benefit with a monthly limit. Claims **MUST** be submitted by month or partial month, but not spanning multiple months, and must include the year. For example: January 2016 - OK; January 15-31, 2016 - OK; January 15 - February 15 - NOT OK.

Things to Include with your Claim

- Fully completed and signed Claim Form.
- Receipt for each expense which includes the date of service. Receipts must be submitted unless they are not provided in the normal course of business. If this is the case, circle NO under the Receiptable portion of the Claim Form.
- Canceled checks and credit card receipts are not acceptable receipts under IRS regulations.

Reminders for Submitting your Claim Form:

- Retain the original of all requests including the substantiation, sending us a copy of the documents only. Pension Dynamics is not responsible for providing copies.
- Please allow 2 business days for your claim to be processed. Payments are not able to be issued until the funds are available in your account.
- If your claim is denied, you will receive a written statement telling you why the claim could not be processed. If we need further information the denial letter will state what you can do in order to have your claim re-processed.
- Do **NOT** combine your claim with your co-workers' claims. It will cause a delay in processing and may not be processed at all.
- If possible scan your Claim Form and all substantiation and email the documents to us at benefits@pensiondynamics.com. This is the preferred method of claim submission as you will get a personal response stating your claim was received.
- You may also Fax your Claim Form to (866) 320-1931
- If you mail your Claim Form please send only copies, not originals, to: Pension Dynamics Company LLC, Attn: Benefits Department, 2300 Contra Costa Blvd., Suite 400, Pleasant Hill, CA 94523-3987.

COMMUTER REIMBURSEMENT

FAILURE TO COMPLETE THIS FORM IN FULL MAY DELAY PAYMENT

Company/Plan Name _____

SECTION 1. EMPLOYEE INFORMATION

Name _____ Last Four Digits of SSN _____

Email Address _____ Daytime Phone Number _____ Evening Phone Number _____

SECTION 2. TRANSPORTATION CLAIMS

CLAIMS CANNOT EXCEED \$255/MONTH

- These expenses must be for a pass, token, fare card, voucher, or similar item for transportation either on mass transit facilities (including BART, Muni, ferry, cable car, etc.) or in a Commuter Highway Vehicle (Vanpool).
- A Commuter Highway Vehicle is any highway vehicle with a seating capacity of at least six adults (not including the driver), and for which at least 80% of the mileage is for the purposes of transporting employees in connection with travel between their residences and their place of employment.
- Individual carpool, bridge toll, or taxi fare does NOT qualify.
- The transportation must be for travel between your residence and/or public transportation location (i.e. Bart station, VanPool) and place of employment.

Provider / Vendor	Month/Year of Service	Receiptable		Requested Amount
		Yes	No	
_____	_____	<input type="radio"/>	<input type="radio"/>	_____
_____	_____	<input type="radio"/>	<input type="radio"/>	_____
_____	_____	<input type="radio"/>	<input type="radio"/>	_____
				Total: _____

If you need additional space to list expenses, please use another form.

SECTION 3. PARKING CLAIMS

CLAIMS CANNOT EXCEED \$255/MONTH

- "Parking expenses" are defined as expenses incurred to park your car on or near the business premises of your employer, or expenses incurred to park your car at a location from which you commute to work by mass transit, Commuter Highway Vehicle (Vanpool), or carpool.

Provider / Vendor	Month/Year of Service	Receiptable		Requested Amount
		Yes	No	
_____	_____	<input type="radio"/>	<input type="radio"/>	_____
_____	_____	<input type="radio"/>	<input type="radio"/>	_____
_____	_____	<input type="radio"/>	<input type="radio"/>	_____
				Total: _____

SECTION 4. PARTICIPANT AUTHORIZATION

I request reimbursement for the above expenses. I certify that any transit and/or vanpooling expense claimed on this form is for the purpose of transportation for me to and from my place of employment. Any vanpooling is in a vehicle with a seating capacity of 6 or more adults (not including the driver), and at least 80% of the mileage is for the transportation of employees in connection with travel between their residences and their places of employment.

I certify that the parking expenses submitted on this claim form for reimbursement are for my automobile to be parked either at a site near my place of business or for a parking space from which I commute by public transit, van, or carpool. The parking space is not near my place of residence.

I certify that I have included any available proof of the claims that I have made above. The claims made here are pursuant to IRS Code Section 132 and I understand that any falsification is subject to penalty under law.

I hereby certify that all of the above claim information is true and correct and compliant with the rules of the plan:

Employee Signature _____ Date _____