

**MILLICAN & ASSOCIATES  
TRANSPORTATION PROGRAM**

**REQUEST FOR REIMBURSEMENT**

Mail or Fax to  
KCI Financial Services, Inc.  
11011 Sheridan Street, Suite 202  
Cooper City, FL 33026  
Tel. 954-443-4443 Fax 954-443-4445

EmployeeName: \_\_\_\_\_ S.S. \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\*Please check if new address ( )  
=====

**Please provide receipts for each expense you are requesting reimbursement**

**Parking Expenses:**

Date Service Provided	Provider Name	Requested Amount of Reimbursement
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Transit Pass Expenses and Vanpooling Expenses:**

Date Service Provided	Provider Name	Requested Amount of Reimbursement
_____	_____	_____
_____	_____	_____
_____	_____	_____

I request reimbursement from my employer's Transportation Plan account for the expenses listed above, and certify that these expenses qualify as eligible expenses under my employer's IRS Section 132 Transportation Fringe Benefits Program.

**EMPLOYEE'S**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_