

Commuter Expense Reimbursement Plan Claim Form



Section I: Employee Information

Please complete the following information, sign and date the form, and return it the claims department at the address listed below.

Name (Last, First, Middle Initial)	Social Security Number	Company Name
Street Address	()	Phone Number
City	State	Zip

Section II: Instructions & Expenses

For all reimbursable expenses, copies of all bills must be attached which show who (name and address) rendered the service, reason for charge and date and amount of charge. Canceled checks are not acceptable receipts.

Expenses (list below)

Item	Date Expense Paid	Reason for Payment	Amount Paid
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Section III: Employee Certification

I certify that all items requested to be reimbursed comply with the Commuter Expense Reimbursement Plan and such items have not and will not be covered by any other plan or program of any employer or other person. The Savitz Organization, Inc. does not accept responsibility for direct payment to any individuals other than the employee.

Employee Signature	Work Telephone	Date
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Attn Claims Department:
 The Savitz Organization, Inc.
 1845 Walnut Street, 14th Floor
 Philadelphia, PA 19103-4755
 (215) 587-0700

TSO Official Use Only:

Processed by: _____

Date Processed: _____