



Commute Expense Reimbursement Account (CERA) Claim form

Employee Name	Department	Employee Number

CERA Contribution Limitations are set by the IRS and subject to change by the IRS. The maximum is \$270.00 per month

Type of Expense	Provider of Service Name	Dates of Service	Amount Requested
Parking:			
Van Pool:			
Mass Transit:			

Supporting Documentation:

- Supporting documentation must accompany this Claim form for each expense submitted for reimbursement.
- An **original** receipt or invoice is required indicating provider's name, address, dates of service; incurred charges; and payments can only be reimbursed for work-related expenses. You should retain copies of the claim form and supporting documentation for your records as those submitted will not be returned.

I understand and agree;

- I request payment of the above expense(s) from my CERA Account for the attached commuting expenses
- These expenses are not covered from any other source.
- The IRS and the City of Salem Commute Expense Reimbursement Account program governs the CERA program and that the CERA program offered through the City of Salem is subject to current government regulations and any future changes in the law.
- I will not use expenses reimbursed through the CERA Account as deductions when filing my individual income tax return.
- I must submit claim reimbursement for eligible CERA expenses incurred during the plan year (January-December) by March 31st of the following year, or I will forfeit those funds.
- Reimbursements will be paid by check and can be picked up by the department or mailed to my home address on file.
- The maximum I can receive is limited to my account balance. Any amounts in excess of my account balance will be put on hold until additional deposits are made.
- Requests will be reimbursed in the order received.
- Contributions to CERA automatically stop the first of any pay period you cease to receive earnings during unpaid leave. Deductions will resume when earnings are sufficient to cover the requested CERA contributions.

Employee Signature

Date

Employer Use Only

HR Representative: _____ Date: _____ Verify eligible for amount requested: Tracking list Original to A/P for reimbursement