Mail To:
ABA, Inc.
P. O. Box 10787
Burbank, CA 91510
(818) 842-0147

FSA - Transportation Statement

NAME OF EMPLOYEE	Calendar Year 2005
PLAN SPONSOR	

For Mileage (please complete this section)

Member	Date of Medical Services	Mileage		Total Miles	Rate / Mile	Total Claimed
		Beginning	Ending			
					$0.15	$

For Parking Fees and Bus, Taxi, Train Fares (attach receipts)

Member	Date of Medical Services	Name of vendor	Type (parking, bus, taxi)	Amount Claimed
				$

Total Claimed $

EMPLOYEE'S SIGNATURE	DATE