



## COMMUTER BENEFIT ENROLLMENT FORM

### I. Account Holder Profile Information

First Name:	Last Name:	SSN:
Date of Birth:	Email Address:	
Mailing Address Line 1:		
Mailing Address Line 2:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Employer:		

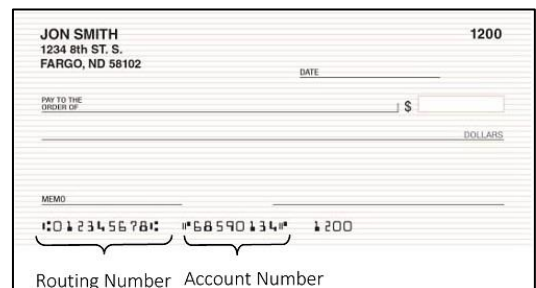
### II. Election

I authorize my employer to make the following pre-tax deductions from my paycheck according to the elections I have chosen below. I understand that I cannot change my election during the plan year unless I request it in writing and my employer allows it. Expenses must be incurred within the plan year that I'm seeking reimbursement from. If I do not utilize all of the monies set aside in this account, then this amount will roll over to the next plan year. My Social Security benefit may be reduced by this election. I will have 180 days from the date of service or 90 days from end of the plan year to turn in the claim. (Manual claims are not allowed for transit expenses) I understand that this benefit is only to be used for my parking/transit expenses to and from work, and that any expenses for my spouse/dependents are not eligible under these plans.

Benefit Month Effective:	Please Check One: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change of Enrollment <input type="checkbox"/> Term Enrollment
Number of Payrolls this plan year: <input type="checkbox"/> 48 <input type="checkbox"/> 24 <input type="checkbox"/> 12 <input type="checkbox"/> Other # _____	
Standard Transit Visa Card Election	Employee Monthly Election: \$ _____
Standard Parking Visa Card Election	Employee Monthly Election: \$ _____

### III. Direct Deposit Setup

Bank Name: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
Account Number:		
Routing Number:		
Address:		
City:	State:	Zip:



### IV. Authorization

Signature: _____ Date: _____	Employer Authorization: _____
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**\*\*Please return this form to your employer for approval. \*\***