

Tax-Free Transportation Program Enrollment/Change

<input type="checkbox"/> New Employee
<input type="checkbox"/> New Enrollment
<input type="checkbox"/> Change
<input type="checkbox"/> Waive Participation

This change is due to:		Date of event: _____
<input type="checkbox"/> Unpaid Leave of absence	<input type="checkbox"/> Spouse becomes or ceases to be employed	<input type="checkbox"/> Death of spouse or child
<input type="checkbox"/> Birth/adoption of a child	<input type="checkbox"/> Divorce/legal separation	<input type="checkbox"/> Change in work hours
<input type="checkbox"/> Marriage	<input type="checkbox"/> Other	

Please complete entire form. If making a change indicate only employee name, Social Security number, items changed, and sign the form

1 EMPLOYEE INFORMATION

Employee name (Last, first, middle initial)	Employer name
Employee address (street)	Employer location/division Group number
(City, State, Zip Code)	How often are you paid? <input type="checkbox"/> Weekly (52/yr) <input type="checkbox"/> Bi-Weekly (26/yr) <input type="checkbox"/> Semi-monthly (24/yr) <input type="checkbox"/> Monthly (12/yr) <input type="checkbox"/> Other
Social Security Number	Date of employment / /
Birthdate / /	Employment status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary <input type="checkbox"/> Other

2 BENEFIT ELECTIONS

Transit Reimbursement Program

I request the following amounts to be deducted from my salary with pre-tax dollars:

Per pay period	Per pay period	Per pay period
Parking \$ _____	Mass Transit \$ _____	Van Pooling \$ _____

I elect to receive my reimbursements by:

Direct Deposit (ACH form required)
 Check
 Debit Card (Annual fee of \$29.95 applies)

3 AUTHORIZATION OR DECLINATION OF PARTICIPATION

Signature and acknowledgement: I request the coverage and classifications listed above and I authorize payroll deductions for these coverages. I understand that my election(s) to either participate or waive coverage is binding for the plan year and the deduction(s), if any, will be in effect for the entire plan year and cannot be revoked unless provided for under the provisions of the plan. I hereby certify the above information to be true to the best of my knowledge and the dependents for whom I will be claiming dependent care and expenses are eligible as my dependents for tax purposes. I further understand future Social Security benefits may be affected should I elect pre-tax salary reduction.

Employer's signature X	Date
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Employer's use only

Effective date of change:	First payroll deduction date
Plan administrator's signature X	Date