

Commuter Benefits Account Enrollment Form



This form is designed to be completed by using your computer and tabbing through the designated fields. If completing a printed copy by hand, please use **black or blue ink, print clearly and only in the spaces provided.**

Social Security Number (SSN)

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Prior to completing this form, contact your benefit services group to determine your employer's preferred enrollment method.

First Name

M.I.

Last Name

Address

City

State

Zip Code

Day Phone

Email

DATE TO BEGIN CONTRIBUTIONS

MM				DD				YY							

NOTE: Elections must be effective the first day of the calendar month.

PARKING

CONTRIBUTION PER MONTH
PRE-TAX \$

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CANNOT EXCEED \$260 PER MONTH

DIVIDED BY # OF PAY PERIODS PER MONTH
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CONTRIBUTION PER PAY PERIOD
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CONTRIBUTION PER MONTH
POST-TAX \$

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DIVIDED BY # OF PAY PERIODS PER MONTH
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CONTRIBUTION PER PAY PERIOD
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TRANSIT

CONTRIBUTION PER MONTH
PRE-TAX \$

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CANNOT EXCEED \$260 PER MONTH

DIVIDED BY # OF PAY PERIODS PER MONTH
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CONTRIBUTION PER PAY PERIOD
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CONTRIBUTION PER MONTH
POST-TAX \$

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DIVIDED BY # OF PAY PERIODS PER MONTH
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CONTRIBUTION PER PAY PERIOD
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Please select your enrollment option below, sign and date your form and submit to your benefit services department:

I elect to participate in my employer's Commuter Benefits Plan as specified above and agree to be bound by the terms of my employer's Plan. I understand that pre-tax deductions will be withheld from each pay period.

I decline enrollment in my employer's Commuter Benefits Plan.

Employee Signature

Date

Employer Section: Control # _____ Employee Company Code _____ Effective Date of Employee Election _____