Commuter Benefit Plan Enrollment Form

Employer Name:

Date of Hire:

Enrollment Effective Date:

Plan Enrollment:

☐ Commuter Benefit Plan

☐ WAIVER - I have been offered an opportunity to enroll, but DO NOT wish to participate

Transit Plan Monthly Contribution Amount
(IRS Maximum Allowable of $130 per month):

Parking Plan Monthly Contribution
(IRS Limit Maximum Allowable of $250 per months):

Employee First Name:

Employee Last Name:

Date of Birth:

Social Security #:

Employee Street Address:

City:

State:

Zip Code:

Employee Contact Phone:

Employee Contact Email Address:

I elect to participate in my Company's Commuter Benefit Plan ("Plan"), and agree to the terms, conditions, and limitations included within the Summary Plan Description provided by my employer. I understand I am responsible for retaining and providing expense receipt at any time, and understand that my inability to do so may result in an expense to be determined as ineligible, and refundable to the Plan.

Employee Signature:

Date of Signature: