



# Enrollment/Change Form

COMMUTER BENEFIT PLAN

Employer

Effective Date of Enrollment (MM/DD/YYYY)

Employee Name - First Name, Middle Initial, Last Name

Hire Date (MM/DD/YYYY)

Member ID (set by employer. Typically an employee ID or SSN.)

Birth Date (MM/DD/YYYY)

Street or PO Box

Email Address

City

State

ZIP

Phone Number

Employment Status:  Full Time  Part Time

I authorize my employer to initiate the following payroll deduction(s) to contribute to my Commuter Benefit Plan:

Type of Account(s):  Parking - Monthly Election: \$   Mass Transit - Monthly Election: \$

This is a:  New enrollment  Change in previous enrollment

### PLEASE CERTIFY THE FOLLOWING:

- I have received and read the printed material which explains my Commuter Benefit Plan and my options under it. I understand that any expenses paid under this plan must be eligible workplace commuting expenses as governed by Internal Revenue Service regulations and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an election that will remain effective until a change form is submitted during open enrollment or when a permissible change has occurred. Any choices above may be modified only as defined in the plan.
- I authorize the amount(s) above to be deducted from payroll as indicated and also authorize any necessary advance on salary deduction (as described herein).
- I authorize the issuance of a Beniversal® Prepaid Mastercard® ("Card"). I agree to use the Card only for eligible plan expenses and to be bound by all provisions of the Cardholder Agreement sent to me with my Card. Furthermore, I understand that if my Card is used for expenses other than those defined in the plan or if I violate the terms of the Cardholder Agreement, my account may be suspended and I will reimburse the plan for the expenses. I also agree to have any non-approved expense and/or applicable replacement card expense deducted from my paycheck on an after-tax basis as an advance on salary.
- I understand that Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. I also understand that I may be required to provide identifying information (e.g. Member ID, address and date of birth) when making inquiries about my Card. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

Signature

Date (MM/DD/YYYY)

RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

### EMPLOYERS ONLY - This section must be complete for employee to be entered into a new enrollment

Deduction Cycle:  Monthly  Semi-monthly  Bi-weekly (2 per month)  Weekly (4 per month)

Pay date of first CBP deduction(s):

Card Issue Month:

**EMPLOYERS: Retain this document for your records. Do NOT send it to BRI. The required information should be sent to Benefit Resource via your normal file exchange process.**