# Enrollment/Change Form
## *Commuter Benefit Plan (CBP)*

Employer

Effective Date of Enrollment *(MM/DD/YYYY)*

Employee Name

Hire Date *(MM/DD/YYYY)*

Member ID *(set by your 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 CBP:

| Type of Account | Monthly Election |
|---|---|
| ☐ Parking | $ |
| ☐ Mass Transit | $ |

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)*

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:

**Submit this document by:**

**Fax:**
(585) 427-9320

**Mail:**
Benefit Resource, LLC
PO BOX 642
Willow Grove, PA 19090

*The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.*
*The Beniversal Prepaid Mastercard is issued by The Bancorp Bank pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark of Mastercard International Incorporated. Card accepted at qualified merchants accepting Debit Mastercard. The Bancorp Bank; Member FDIC.* 