

**TRANSPORTATION FRINGE BENEFIT PLAN
ENROLLMENT FORM & DEDUCTION AGREEMENT/DIRECT DEPOSIT AUTHORIZATION**

Employer: _____ Division (if applicable): _____

Employee Name: _____ Soc. Sec. No: _____
Last First MI

Date of Birth: _____ Home Address: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Payroll Frequency: Weekly (52) Bi-weekly (26) Semi-monthly (24) Monthly (12) Other _____

Date of Hire: ____/____/____ Effective Date: ____/____/____ Payroll Start Date: ____/____/____

Benefit Election Authorization or Waiver

I elect the following coverage under my employer's Transportation Fringe Benefit Plan ("Plan") and authorize my employer to make the following deductions from my paycheck (less any employer contributions) on a pre-tax basis (this amount will be spread among my payroll deductions for the month):

Benefit Elections:	Transportation Details	Deduction Amount (Per Pay period)
A. Qualified Parking Election <small>(Qualified Parking subject to statutory maximum as determined by IRS)</small>	Name of Entity providing parking: _____ _____ Location: _____ Name of Entity providing Transit Pass: _____	\$ _____
B. Transit Pass and Commuter Highway Vehicle (CHV) Election <small>(Transit Passes and CHV combined per month subject to statutory maximum as determined by IRS)</small>	Name of Entity providing CHV: _____ _____	\$ _____
<input type="checkbox"/> Cancellation of Previous Election		

I elect to **discontinue** my participation in the Plan and direct my employer to stop my payroll deductions as soon as practicable.

By signing below, I understand that:

- I am authorizing my employer to reduce my compensation by the amount specified per month.
- Any changes I wish to make to my election must be made on a new Enrollment Form, will be prospective only and will be made by my employer as soon as practicable.
- My election will be revoked upon termination of employment or if my eligibility ceases for any reason.
- Pre-tax deductions reduce my compensation for Social Security tax purposes and may reduce my Social Security benefits as a result.
- Any amounts remaining in my account after reimbursing my eligible transportation expenses for a month will be carried over to a subsequent month. If I stop my Plan participation, any amounts remaining in my account after reimbursing my eligible transportation expenses will be forfeited.
- I also revoke any previous Plan election and replace such election with this election (if applicable) and certify that I will use any Plan benefits only for the purposes of commuting to and from my place of employment.

Employee Signature: _____ Date: _____

Authorization for Direct Deposit of Transportation Fringe Benefit Plan Reimbursements

Complete this section to have your reimbursements deposited directly into your checking or savings account. (Note: Please allow up to 30 days for the direct deposit to be operational. After direct deposit has been activated, you will be sent a direct deposit advice showing the amount that has been deposited in your account.)

Bank/Institution Name:	Bank/Institution Address:
	Street City State Zip

**Routing and Transit Number: _____ Account Number: _____ Account Type: Checking Savings

- **Note:
- If you have designated a Checking Account, please attach a copy of a voided check. Failure to attach a copy of a voided check may result in a delay in entering your enrollment information and/or processing reimbursements.
 - If you have designated a Savings Account, please validate the account number as it appears on your statement.
 - In order to verify bank routing, the first reimbursement processed after the Direct Deposit Authorization is received may be in the form of a check.
 - Your financial institution may have a separate routing number for ACH transactions; please verify the routing number with your financial institution to prevent any delay in receiving reimbursements.

I authorize Infinisource, Inc. to initiate credit/debit entries for reimbursement of my Transportation Fringe Benefit Plan claims to the Bank/Institution listed above into the account specified.

Employee Signature: _____ Date: _____

Infinisource, Inc. has incorporated the HIPAA Privacy Requirements to reflect our organization's business practices regarding your coverage.

Fringe Benefits Administration • PO Box 488 • Coldwater, MI 49036-0488
866-370-3040 • Fax: 800-379-5670 • www.infinisource.net • E-mail: fsa@infinisource.net

