ENROLLMENT FORM

COMMUTER BENEFIT PLAN

(PLEASE PRINT CLEARLY)

Benefit Resource, Inc.
245 Kenneth Drive
Rochester NY 14623-4277
Phone: (800) 473-9595
www.BenefitResource.com

EMPLOYER:

EFFECTIVE DATE OF ENROLLMENT: / /

A. EMPLOYEE INFORMATION

Member ID:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / /

Hire Date: / / Employee Status *(please check one)*: ☐ Full-Time ☐ Part-Time

Email Address: _____

(Note: Benefit Resource, Inc. will only use your email address to communicate with you regarding your plan.)

B. COMMUTER BENEFIT PLAN (CBP) ACCOUNTS

Please enter your CBP election(s):

Type of Account	Monthly Election
☐ Parking	$ _____
☐ Mass Transit	$ _____

C. EMPLOYEE CERTIFICATION *Return signed form to your employer.*

- 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 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: _____ / _____ / _____

D. PAYROLL DEDUCTION INFORMATION *Employer must complete this section for employee to be enrolled.*

- **Deduction cycle:** ☐ monthly ☐ semi-monthly ☐ bi-weekly *(2 per month)* ☐ weekly *(4 per month)*
- **Pay Date of first CBP deduction(s):** _____/_____/_____
- **Card Issue Month:** _____

Your Prepaid Mastercard is issued by The Bancorp Bank pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark of Mastercard International Incorporated. The Bancorp Bank; Member FDIC.