Enrollment Form

Commuter Benefits

Employer Name:		SSN:
Employee Name (Last, First MI):		
Date of Birth:		
Home Street Address:		
City:	State:	Zip:
Home Phone:		Email:

Commuter Benefits

Benefit	Per Pay Period Amount
Commuter Transit Account (qualified commuting expenses)	
Commuter Parking Account (qualified parking expenses)	

IMPORTANT: Please read the following before signing this enrollment form. My employer and I agree that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections (selected above) set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election as set forth in my employer's plan. I acknowledge that I have received, read and understand the Summary Plan Description. I understand that the take care Card is available to pay only qualified expenses and that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the Card from any other source. I understand that when using the Card I must keep all receipts and that, on occasion, I may be asked for documentation of charges made with my Card. I also understand that if a payment is made that is not for qualified expenses, I will repay my employer for any expenses not repaid by me, and I authorize my employer to deduct the amount from my paycheck (if permitted by state law).

Employee Signature   Date

Return completed form to your employer.