CHANGE FORM

QUALIFIED TRANSPORTATION EXPENSE PLAN

(PLEASE PRINT CLEARLY)

Benefit Resource, Inc.
plans that perform

2320 Brighton-Henrietta Townline Rd
Rochester, NY 14623
Phone: (800) 473-9595
Website: www.BenefitResource.com

EMPLOYER:

EFFECTIVE DATE OF CHANGE: / /

A. EMPLOYEE INFORMATION

Member ID:

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

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: E-mail Address:

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

B. QUALIFIED TRANSPORTATION EXPENSE (QTE) ACCOUNTS *Please enter any changes in QTE election(s) below.*

Please enter your *new* QTE election(s):

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

C. ELECTION CHANGE INFORMATION *Please check applicable event(s).*

Reason for Change *(check all that apply):*

- ☐ Participant's termination of employment
- ☐ Change in work schedule
- ☐ Change in monthly QTE expenses
- ☐ Change in residence or worksite
- ☐ Open Enrollment
- ☐ Other _____

Type of Change *(check all that apply – do not complete if employment is terminating)**:***

Parking	Mass Transit	
☐	☐	Increase monthly election
☐	☐	Decrease monthly election
☐	☐	Stop deduction *(account will remain open)*
☐	☐	Close account *(account can no longer be used; funds are forfeited)*

D. EMPLOYEE CERTIFICATION

- By signing and submitting this change form, I authorize all changes as indicated above and understand that any changes must be permissible under IRS regulations as defined in the Plan. I also understand that any expenses paid under this Plan must be eligible expenses as governed by IRS regulations and must not be reimbursed from any other source.
- 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).
- If I use the eTRAC® MasterCard®, I agree to use the card only for eligible Plan expenses and to be bound by all provisions of the *eTRAC MasterCard Agreement* sent to me with my card. Furthermore, I understand that if my eTRAC MasterCard is used for expenses other than those defined in the Plan or if I violate the terms of the *Agreement*, I may pay a surcharge for each non-approved expense and may lose eTRAC MasterCard privileges and will reimburse the Plan for the expenses. I also agree to have any non-approved expense and/or 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 with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my eTRAC 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: _____ / _____ / _____

E. PAYROLL DEDUCTION INFORMATION *Employer must enter any changes below.*

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

Please return completed form to your employer.