Benefit Resource, Inc.
plans that perform

CHANGE FORM
COMMUTER BENEFIT PLAN
(PLEASE PRINT CLEARLY)

245 Kenneth Drive
Rochester NY 14623-4277
Phone: (800) 473-9595
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 #: Birth Date: / / Gender: ☐ Male ☐ Female

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 any changes in CBP election(s) below.*

Please enter your *new* CBP 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 CBP 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 or re-opened)*

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

- By signing and submitting this change form, I authorize all changes as indicated above and understand that any changes must be permissible under Internal Revenue Service (IRS) regulations as defined in the plan. I also understand that any expenses paid under this plan must be eligible workplace commuting 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 Prepaid MasterCard® benefit card ("Card") issued by the Benefit Resource, Inc. bank, I agree to use it only for eligible plan expenses and to be bound by all provisions of the 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 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 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. 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: _____ / _____ / _____

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 CBP deduction(s):** _____/_____/_____

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