

Transportation Enrollment

Employer _____ **Division (if applicable)** _____

Employee name _____ Soc. Sec. No. _____

Date of birth _____ Home address _____

City _____ State _____ Zip _____ Email _____

Payroll Frequency **Weekly (52)** **Biweekly (26)** **Semimonthly (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 indicated deductions from my paycheck (less any employer contributions) on a pre-tax basis (amount divided among monthly payroll deductions):

Benefit Elections	Transportation details	Deduction amount (per month)
Qualified Parking (amount subject to statutory maximum as determined by IRS)	Name of entity providing parking _____ Location _____	\$ _____
Transit Pass and Commuter Highway Vehicle (CHV) (combined per month amount subject to statutory maximum as determined by IRS)	Name of entity providing Transit Pass _____ Name of entity providing CHV _____	\$ _____

Cancellation of previous election

I elect to discontinue 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 election changes I wish to make 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.

I authorize Infnisource, Inc. to initiate credit/debit entries for Transportation Fringe Benefit Plan claims reimbursement to the listed bank/institution into the account specified.

Employee Signature _____ Date _____

Isolved Benefit Services has incorporated the HIPAA Privacy Requirements to reflect our organization's business practices regarding your coverage.

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Transportation Reimbursement Form

Employee name _____ ID or SS # _____ Employer _____

Daytime phone # _____ Home address _____
Number/Street City State Zip

Please check if this is a new address

- **Qualified Parking** covers parking on or near the employer's business premises or at a location from which the employee commutes to work.
- **Transit Passes** are tokens, fare cards, passes, vouchers, etc., used for transportation on mass transit facilities or provided by any person in the business of transporting persons for compensation or hire in a highway vehicle carrying at least 6 adults (excluding driver).
- **Vanpooling** is transportation in a commuter highway vehicle provided by an employer for travel between the employee's home and place of employment.
- **Bicycle Commuting** covers up to \$20 per month in expenses related to regular bicycle use for a substantial portion of the travel between the employee's home and place of employment in those months where the employee receives no other benefits under the Transportation Fringe Benefit Plan. These expenses include bicycle purchase, improvements, repairs and storage. **Please review Plan materials to determine if your employer offers this benefit.**

Date of Service From m/d/y to m/d/y	Provider Name	Type of Expense	Amount of Reimbursement Request
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			
/ / to / /			

PLEASE NOTE: Receipts are required for reimbursement of all expenses, unless a receipt is not provided in the ordinary course of business (e.g., metered parking) and you certify by your signature below to the type and amount of expenses incurred. Your employer has the right to refuse reimbursement if there is reason to doubt your certification.

I certify that:

- The statements and representations in this Reimbursement Form are complete and true.
- I am requesting reimbursement solely for the purposes of my own commuting to and from work.
- The services listed above occurred on the dates indicated.
- Expenses listed are qualified expenses under my employer's Transportation Fringe Benefit Plan (the Plan).
- These expenses have not been reimbursed and are not reimbursable under another plan.
- These expenses have not been reimbursed previously under this Plan.
- I authorize a deduction in my account in the amount of the reimbursement requested.
- The provider where I am receiving these services from only allow cash reimbursement.
- The Benefits Card declined when trying to purchase my transportation.
- The provider does not accept Benefits Card nor vouchers.

Employee Signature _____ Date _____
 (You must sign this form to be reimbursed.)

Claim confirmation: You can easily view your claim status 24 hours a day, 7 days a week at www.infinisource.com. If you choose to mail your claim, please do not fax the same claim. Claims may be faxed to 800-379-5670. Keep the fax confirmation for your records. If faxed, allow 48 hours before checking the website or calling for the status of your claim.