TRANSPORTATION FRINGE BENEFIT PLAN ENROLLMENT FORM

EMPLOYER MUST FILL-IN				
Re-enrollment ___	New ___	Change ___		
Effective Date _____				
1st Deduction date _____				
1st Deduction amount _____				
Payroll Schedule	W	B	S	M	Q

I. EMPLOYEE INFORMATION - Please print clearly

Company Name: **Diocese of Long Island**

First Name: _____ MI:_____ Last Name: _____

SSN: _____ DOB: _____ Gender: ☐ Male ☐ Female

Mailing Address: _____

City: _____ State: _____ Zip:_____

Email: _____ Work Phone: _____

II. EMPLOYEE ELECTIONS

	CONTRIBUTION PER MONTH	DIVIDED BY # OF PAY PERIODS PER MONTH	CONTRIBUTION PER PAY PERIOD
Pre-tax Transportation Expenses	$_____._____ ($340/mo. max /$0 min)	÷ _____	= $ _____.____
Pre-tax Parking Expenses	$_____._____ ($340/mo. max /$0 min)	÷ _____	= $ _____.____
Post-tax Transportation Expenses	$_____._____ (unlimited)	÷ _____	= $ _____.____
Post-tax Parking Expenses	$_____._____ (unlimited)	÷ _____	= $ _____.____

I understand that:

* By signing this enrollment form, I elect to receive pre-tax benefits under the commuter benefits program.
* By electing coverage, an amount equal to the cost of my monthly transportation expenses will be deducted from my compensation on a pre-tax basis. Such compensation reduction will continue for each month until this agreement is amended or terminated. Any previous election and agreement under the plan relating to the same benefits, including any prior election form, is herby revoked.
* The commuter benefits elected are for expenses incurred for parking on or near my worksite or on or near a location from which I commuter by carpool; or for expenses related to the use of a commuter highway vehicle, mass transit, or transportation provided by any person in the business of transporting persons for compensation or hire, if such trasportation is in a commuter highway vehicle.
* Compensation reductions under this agreement will reduce my compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.
* Any amounts remaining in my reimbursement accounts at the end of the year will rollover.
* If my Prepaid Benefit card is lost/stolen or I would like additional cards there will be a $10.00 fee charged to my FSA account.
* Any expenses I pay for with the Prepaid Benefit card, or for which I claim reimbursement have not been nor will be reimbursed elsewhere.
* Manual reimbursements will no longer be accepted for Transportation accounts. Use of the Prepaid Benefit card will be the option available.

III. AUTHORIZATION AGREEMENT FOR ACH DEBITS/CREDITS - Please attach a copy of a voided check (not deposit slip)

☐ Check ☐ Direct Deposit ☐ Checking ☐ Savings ☐ Keep my current Direct Deposit information.

* If a deposit slip is submitted to BAI, we will automatically change your method of reimbursement to check. If you are new and check off Direct Deposit but do not submit a check or you submit a deposit slip, your method of reimbursement will be changed to check.
* I, hereby, authorize Benefit Analysis Inc., to initiate debits and/or credits to or from my bank account listed on my check, and to debit and credit the same to such account with the agreement that the only debits to be made will be for the sole purpose of correcting a prior FSA reimbursement error. I acknowledge the origination of ACH transactions to or from my account must comply with the provisions of U.S. law.
* The authorization is to remain in full force and effect until Benefit Analysis Inc., has received written notification from the employee above.
* It may take up to 72 business hours to have your reimbursement appear in your account, depending upon the automated clearing house utilized by your bank. We suggest that you contact your bank to confirm when these funds become available in your account. Benefit Analysis, Inc. shall not be responsible for any checks, or other debt obligations you make whereby you have assumed these funds are available.
* If a direct deposit is returned to Benefit Analysis, Inc. we will charge a $35.00 reissue fee assessed to the employee. If you do not attach a voided check we will assume you have elected to be reimbursed via check. If a check is lost or stolen, there will be a $35.00 stop payment fee assessed to the employee to reissue the check.

Signature _____ Date _____