AMERICAN BENEFITS GROUP

COMMUTER BENEFIT ELECTION & CHANGE FORM

Name: _____ **SSN:** _____

Home Address: _____ **Email:** _____

City, State, Zip: _____ **Phone:** _____

Employer: _____ **Date:** _____

I would like to enroll in or make changes to my commuter benefits effective _____

I understand that I can only change my deductions at the beginning of a coverage period. If I do not submit the request in time, the change will not take place until the beginning of the subsequent coverage period. (Any amount elected in excess of the current Pre-Tax monthly limit will be an After Tax contribution)

☐ Qualified Parking – Monthly Change from: $ _____ To: $_____

☐ Qualified Transit - Monthly Change from: $ _____ To: $_____

☐ Qualified Bike – Monthly ☐ $20 maximum per month

IMPORTANT: If you terminate employment any funds remaining in your Transit account will be forfeited.

No cash reimbursements for Transit Expenses.

I have read and understand the Plan Description and agree to act according to its provisions.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

EMPLOYER PLEASE COMPLETE

Effective Date: _____ First Deposit Date for this Change: _____

Submit this form to your HR Department

If you have any questions on how to complete this form,
call American Benefits Group at 800-499-3539 or email support@amben.com