FOOTHILL-DE ANZA
Community College District

Office of Human Resources and Equal Opportunity
Commuter Benefits Plan Enrollment Form

PLEASE PRINT. All information is required or your enrollment cannot be processed.

Employee Name (Last, First): _____

SSN: _____Date of Birth (MM-DD-YYYY): _____

Home Street Address: _____

City: _____State: _____ZIP Code: _____

Home Phone: _____Email: _____

Plan Year start (MM/DD/YY) _____/_____/_____ and end _____/_____/_____

Option 1:
Commuting Benefits –Transit Account (before taxes)
Minimum: $20/mo. Maximum: $130/mo.

____YES I elect to contribute $_____**per pay period** to fund my account that pays qualified *transit* expenses

____NO I decline this option and understand that the effective date of change is **_____.**

Option 2:
Commuting Benefits – Parking Account (before taxes)
Minimum: $20/mo. Maximum: $250/mo.

____YES I elect to contribute $_____ **per pay period** to fund my account that pays qualified *parking* expenses

____NO I decline this option and understand that the effective date of change is _____.

IMPORTANT: Please read the following before signing this enrollment form.

I understand that my taxable income will be reduced each pay period during the year by an equal portion of the benefit elections (selected above) set forth above and that qualified expenses will be paid on a tax-free basis. I understand that I may change my election as set forth in my employer's plan. I understand that the program is available to pay only IRS qualified expenses and that qualified expenses cannot be reimbursed by any other plan and I understand that I must keep all receipts for auditing and submitting claims purposes. I acknowledge that the IRS requires that the Plan Administrator must receive ALL claims for qualified expenses within 180 days after the service date is provided in order for it to be considered for reimbursements. Further, I understand that unused fund(s) will be rollover for the next plan year for active participants. In an event that I separate active employment, I have up to 90 days to submit a claim. Unused fund that are not requested upon termination of employment is forfeited.

Employee Signature_____Date_____

Return completed form to the Benefits Unit.
Fax this form **to (650) 949-6299** or pdf/email to MyBenefits@fhda.edu
Questions, call: 650-949-6224