



## TRANSITBENEFIT PLANS

740 Admin 742 Pedagogues 744 PARA 745 School Based 746 Per Diem 202 Custodians Please select one: Hourly Support Teachers

i lease select one.									Hourly Su	ıppo	rt I	eachers				
EMPLOYEE ACTION																
NEW (Enroll) CHANGE PERSONAL INFORMATION (Change Mailing Address, Email or Telephone)					CHANGE DEDUCTION (Change Amount Deducted from Pay each Month)				SUSPEND DEDUCTION (Temporarily Stop Transit Plan Deduction from Pay. DOES NOT APPLY TO Annual Transit Card.)					CANCELLATION (Terminate Payroll Deduction)		
EMPLOYEE IDENTIFICATION (All fields in this section are required and must be filled out completely. Please Print.)																
Employee Reference	#*		EIS													
Name (First/Middle/l	_ast)															
Address Line 1								Address Line 2**								
City/State/Zip								Telephone								
Email Address																
* Located on your pay stat			** Apt.#, Fl													
TRANSIT PLAN A												o the Commuter	Benefi	t Plan of your		
Annual Tr		Admir	n Fee		UI (\$1.25 Monthly Admin Fee through Pa		Unrestricted h Payroll Deductions)	(\$2.05 Monthly Admin Fee through Payroll Deduction		ugh Payroll Deductions)						
Employee Initials Monthly Deduction Amt			Employee	М	Monthly Deduction Amt.			Employee Initials		nthly Deduction Amt.	Employee Initials		Monthly Deduction Amt.			
		32.00 per pay date)*	t		(\$		132.00 0 per pay date)*							\$		
CUCPEND TRANSIT DI AN DEDUCTION (SATA MATA MATA MATA MATA MATA MATA MATA																
SUSPEND TRANSIT PLAN DEDUCTION (DOES NOT APPLY to Annual Transit Card																
Submit at least 2 weeks before you want to suspend your deduction. Remember, administrative deductions will continue when applicable. If you are also enrolled in the Commuter Benefits Parking Plan, the parking plan will be suspended for the same period. Please note this will only suspend your payroll deduction. To also suspend your transit pass orders you must do so directly with ECBS at www.commuterbenefitsnyc.com or (833) 584-8109.  MONTH DAY YEAR  MONTH DAY YEAR																
PAY DATE TO SUSI	PEND DI	EDUCTION		PAY DATE TO RESUME DEDUCTION						//	Щ					
EMPLOYEE CERT	ΓIFICA	TION														
I hereby authorize the City of New York to deposit my payroll deduction as indicated above into my ECBS Commuter Benefits Transit Account.  I also grant authorization for the reversal of a credit to my account in the event the credit was made in error. I understand that, under the "National Automated Clearing House Association" operating guidelines and rules, the City of New York can only reverse the amount of the incorrect direct deposit.  I understand, according to the Internal Revenue Code, that the average monthly amount of my transportation deductions should not exceed my average monthly cost of public transportation to and from work. If my average monthly cost of public transportation to and from work should change, I will change my deduction plan to accommodate my new circumstance. Furthermore, no reimbursement will be provided for pre-tax transportation fringe deductions. Upon termination, voluntary or otherwise, any funds remaining in my Transit Account will be available for use for a period of 90 days from the effective date of termination. Residual funds remaining in the account beyond a period of 90 days will be forfeited.  I understand there is a monthly fee to cover administrative costs of the program. Said fee will either be paid by the City of New York to ECBS on my behalf and will be added to my taxable earnings as a fringe benefit each month or will be deducted from my post-tax pay each month. The administrative charge is non-refundable. The administrative fees and charges are as follows:																
TRANSIT PLAN			ONTHLY	FEE					CHARGE METH							
Annual Transit Card  Commuter Card No Admin				_	1.25 1.25						Added to earnings as a taxable fringe benefit.  Added to earnings as a taxable fringe benefit.					
Commuter Card Unrestric				_	1.25						Reduced from earnings as a post-tax deduction.					
Transit Pass \$2.05 Reduced from earnings as a post-tax deduction.  I grant authorization for the City of New York to provide my enrollment information, including mailing address, phone number, and email address to ECBS use exclusively related to the administration of the program.  I understand that this authorization will remain in effect until I submit a new request for a change or cancellation.  I understand that my Commuter Benefits Transit Account balance and information will be maintained by ECBS and are accessible online at www.commuterbenefitsnyc.com or by calling ECBS Customer Service at (833) 584-8109.																
Employee Signature DATE												DATE MONTH	/ DAY	YEAR		
AGENCY PAYROLL SECTION																
I certify that the above d	ata was er	ntered in NYCAF	<sup>2</sup> S via EForms	:												
Prepared By (Please			S	ignature	е					Date						