STATE OF TENNESSEE GROUP INSURANCE PROGRAM

FLEXIBLE BENEFITS PLAN ENROLLMENT — TRANSPORTATION AND PARKING

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

Complete this form only if you wish to participate in the transportation or parking flex accounts.

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

HOME ADDRESS	CITY	STATE	ZIP CODE

DEPARTMENT NAME	DEPT ID / BUDGET CODE	DATE HIRED	EMPLOYEE ID (IF KNOWN)

WORK PHONE	PAYROLL FREQUENCY (PAYCHECKS PER YEAR)	ENROLLMENT STATUS
	❑ 12 ❑ 24 ❑ Other _____	❑ Enroll ❑ Change Deduction ❑ Stop Account

REIMBURSEMENT ACCOUNT ENROLLMENT

Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact your HR office for additional literature or you may call 615.741.3590.

TRANSPORTATION REIMBURSEMENT ACCOUNT

Maximum allowable contribution is $315 per month

Monthly Payroll Deduction: If you are paid semi-monthly, this amount will be divided between your paychecks.

$ _____

PARKING REIMBURSEMENT ACCOUNT

Maximum allowable contribution is $315 per month

Monthly Payroll Deduction: If you are paid semi-monthly, this amount will be divided between your paychecks.

$ _____

AUTHORIZATION

Transportation and Parking Accounts do not have an annual enrollment period. I understand the amount selected will remain in effect until I either change the elected amount or notify Benefits Administration to terminate my account.

I hereby authorize my employer to reduce my gross salary before federal, state and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file a change in deduction.

I understand that on December 31, any remaining balance from the previous year will automatically roll into an active account of the same type. If there is not a current account, remaining balances from the previous year will be forfeited.

I understand and agree that the state will not incur any liability resulting from either my participation in or my failure to accurately complete this enrollment application.

I understand that if I terminate employment during the plan year, I have 90 days from my termination date to submit claims for eligible expenses. Any funds left in my account(s) after the 90 days are forfeited.

I understand that I must file claims for the previous year by April 30 of the following year and that any prior year claims submitted after April 30 will be denied.

EMPLOYEE SIGNATURE	DATE

Return this application to your human resource office after making a copy for your records.

For questions regarding enrollment, please call Benefits Administration at 615.741.3590 or 800.253.9981.