

**NEW YORK CITY HEALTH + HOSPITALS  
TRANSIT BENEFIT PROGRAM  
ANNUAL PREMIUM TRANSITCHEK METROCARD ENROLLMENT/ CANCELLATION FORM**

**IMPORTANT INFORMATION FOR EMPLOYEES:**

Your unlimited ride Annual Premium TransitChek Metrocard is provided as a pre-tax benefit contingent upon continuing deductions from your gross pay. Your taxable wages reported to the IRS at the end of the year will be reduced by the total amount of your Annual Premium TransitChek Metrocard deduction and increased by the value of the administrative fee paid by H+H to the provider of the Annual Premium TransitChek Metrocard for each payday that you have a TransitBenefit deduction.

**INSTRUCTIONS:**

TO ENROLL: Fill out sections 1 and 2. Make sure you sign the Address Certification and the Employer Authorization  
TO TERMINATE YOUR PARTICIPATION: Fill out Sections 1 and 3.  
Email completed form to: [payrollinquiries@nychhc.org](mailto:payrollinquiries@nychhc.org)

**SECTION 1: EMPLOYEE ENROLLMENT INFORMATION**

EMPLOYMENT ID NUMBER: \_\_\_\_\_ NAME: \_\_\_\_\_  
LAST FIRST MI

FACILITY: \_\_\_\_\_ WORK TELEPHONE NUMBER: \_\_\_\_\_  
( )

HOME ADDRESS: (This is the address to which your Annual Premium TransitChek Metrocard will be mailed. Please make sure the address is correct.)

STREET NUMBER \_\_\_\_\_ APT. \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE + 4 \_\_\_\_\_

**ADDRESS CERTIFICATION:**

I certify that the above address is my current home address.

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\*Please log into [Employee Self Service](#) if you need to update or view your current address on file.

**SECTION 2: EMPLOYEE AUTHORIZATION**

I understand that the use of my Annual Premium TransitChek Metrocard is contingent upon continuing deductions from my gross pay and that, if for any reason, such deductions stop, my Annual Premium TransitChek Metrocard will be de-activated. I understand that if my Annual Premium TransitChek Metrocard is lost or stolen, it will be replaced with one that will be active as of the first day of the month following the month during which the lost or stolen Annual Premium TransitChek Metrocard was active.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**SECTION 3: TERMINATION OF SERVICE REQUEST**

I hereby request New York City Health + Hospitals terminate my enrollment in the Annual Premium TransitChek Metrocard Program as soon as administratively possible.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**FOR FACILITY PAYROLL DEPARTMENT USE ONLY**

ENROLLMENT REJECTION:  
NON-ELIGIBILITY

Other – List reason below

Reason: \_\_\_\_\_

Informed employee of rejection

ENTRY INFORMATION:  
ENTERED BY: \_\_\_\_\_

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Eff. Payroll \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_