NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

TRANSIT BENEFIT PROGRAM
ANNUAL PREMIUM TRANSITCHEK METROCARD ENROLLMENT 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 HHC to the provider of the Annual Premium TransitChek Metrocard for each payday that you have a Transit Benefit 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.

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. I understand that if the above address does not match the address in HHC's Personnel and Payroll records, such records will be corrected to reflect the above address as my current home address.

____
EMPLOYEE SIGNATURE

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 the New York City Health and Hospitals Corporation 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

- ☐ W1/B2 payee
- ☐ Other – List reason below
- ☐ Not covered by City-Wide Agreement

Reason: ____________________
____

- ☐ Informed employee of rejection

Name: ____________________ Date: _____/____/_____

ENTRY INFORMATION:
ENTERED BY: ____________________ DATE: ____/____/____

Eff. Payroll _____/____/____