



Section 132 Transportation/Parking Plan Set-up Form

Full legal name of the Employer: _____

Type of Benefit: Transportation Parking Effective Date: _____

Plan Year: _____ Begins (mm/dd): _____ Ends (mm/dd): _____

Is first year a short Plan Year? Yes / No

If yes, please provide: Start Date: _____ End Date: _____

Do you currently have a Commuter Plan in place with another vendor? Yes No

If yes, will ASi administer the run-out of your current plan? Yes No

Plan Number: 501 502 503 504 505 506

(if none selected, one will be assigned)

Pay Periods

Weekly Bi Weekly Semi Monthly Monthly

Plan Start Date	Plan End Date	First Payroll Date	Last Payroll Date	# of Payrolls per plan Year

Is this Plan subject to FMLA?

No (1-49 employees) Yes (50+ employees)

Plan Eligibility

___ The same day employee becomes eligible for Group Medical Plan

___ The first regularly scheduled working day on which the employee first performs an hour of service for the employer for compensation

___ Other: _____

Funding Options

Please select from one of the below options:

(For more details on our funding options, please refer to our Funding Guide)

Debit Card on Group Banking

- *Please complete the Bancorp ACH form (this is the account that will be linked to the debit cards).*
- *Please complete the ASi ACH form for manual claims that may be submitted.*
- *Debit cards require a 5% deposit of the aggregate participant annual election amount. Deposit must be received prior to debit cards being issued*
- *Debit card security deposit will be refunded after 120 days of the Plan termination*
- *Debit cards are valid for three years from the issue date. Cards are not reissued for new elections if the participants card is still valid. If a new card is requested, a fee will incur for the new cards.*

Non-Debit Card Funding (Choose one of the following)

- ACH for Claims** (Debits your account for claim utilization on a weekly basis, as applicable. ACH authorization form must be completed.)
- ACH for Contributions** (Debits your account for contribution each applicable pay period. ACH authorization form must be completed.)
- Mail for Contributions** (Client to mail contribution check to ASi each pay period.)

A contribution report must be submitted to ASi each pay period

Please indicate if any of the following employee classifications are going to be excluded from enrolling in the plan:

___ There are no exclusions; or

The following classes of employees are excluded (check all that apply):

___ Leased employees

___ Contract workers and independent contractors

___ Temporary employees and casual employees

___ Individual paid by a temporary or other employment-staffing agency

___ Employees covered under a collective bargaining agreement (Union)

___ Other (specify): _____

Eligibility Requirements

Employee has been employed by the Employer for _____ consecutive calendar days and is regularly scheduled to work _____ hours or more per week; or

___ Other (Specify): _____

Employees who first become eligible to participate in the plan mid-year may commence participation on:

___ The first day of the month after eligibility requirement has been satisfied

___ The first day of the following plan year

Employees who are terminated for any reason and are rehired within 30 days will be subject to eligibility requirements as a new hire: Yes / No

Employees who cease to be eligible for reasons other than termination such as reduction in hours or disability leave of absence and are reinstated to eligible status outside of 30 days:

___ Must complete the stated waiting period in order to become eligible

___ Do not need to complete the waiting period before becoming eligible

Claims Filing Deadlines

Unless you advise our office differently, the deadline to file claims for active employees will default to 90-days from the end of the plan year. For terminated employees, the deadline is 90-days from the employees termination date. All services must be rendered while the employee was in an active status.

Please select from one of the following options on how your company would prefer to receive the monthly invoices for administrative fees:

- U.S. Mail E-Mail

Please provide the e-mail address if different than what is listed on the application: _____

Certification of Accuracy

I, _____ certify that the information provided on this form is accurate to the best of my knowledge. I understand that ASi will utilize this information for preparation of our Plan Documents.

Signature

Date

Title

ASi Internal Use Only:

Administration Fees: _____
Implementation Fees: _____
Per Participant/Per Month: _____
Annual Fee: _____
Employee Statements: _____
Other: _____