SmartBenefits®
Salary Reduction Agreement/Enrollment

_New Enrollment _Change of Elections and/or Registration Number _ Cancel Participation Beginning _____

Employee Information: (Please print clearly.)

Employee Name: _____

XXXXX Department: _____

Pre-Tax Elections: Please note: The amount elected for SmartBenefits® vouchers and for the SmarTrip® card is combined under the monthly max. rate $230

Elections for SmarTrip® Card: Transit Only
The amount elected taken out bi-weekly will be half of the monthly election. (For example: Election amount =$100; deduction will be $50 twice a month).

Registration Number: _____

Monthly *SmarTrip*® Card Amount: (The maximum monthly amount is $230) $_____

Elections for SmartBenefits® Vouchers: Only available for MARC, VRE, MTA long distance commuter buses (Keller, Dillion, Erye) riders.
The amount elected taken out bi-weekly will be half of the monthly election. (For example: Election amount= $100; deduction will be $50 twice a month).

Monthly SmartBenefits® Voucher Amount: (The maximum monthly amount is $230) $_____

How would you like your SmartBenefits® Vouchers? (Please enter the quantity)

$1 _____ $10 _____ $30 _____

Elections for Metro Parking Stations: Parking Only
The amount elected taken out bi-weekly will be half of the monthly election. (For example: Election amount= $100; deduction will be $50 twice a month).

Registration Number: _____

Monthly *SmarTrip*® Card Amount: (The maximum monthly amount should not exceed $105) $_____

I authorize payroll deductions for the purpose of participation in the OMV Medical Inc. transit benefit (IRS Code Section 132) program from my annual base salary based on my election above. I understand that by signing and submitting this form I am making a binding election on a **monthly** basis. This agreement will remain in effect until I opt out of the program or change my election; otherwise this agreement will remain in effect until any changes are desired. I understand that if I leave OMV Medical Inc. during a participation period, that this agreement will become null and void.
I further understand that this form must be signed and dated prior to my plan effective date in order to be eligible to participate in this quarter.

Signature: _____ Date: _____

For Human Resources Use Only:

Date Received: _____ Start program: _____