

HRA accounts

Enrollment or change form

* This information is mandatory. Enrollment may be delayed if fields with an asterisk are not filled out.

Section 1 Application reason

PLEASE PRINT CLEARLY

| | | |
|--------------------------|-----------------|------------------|
| * Reason for application | * Change reason | * Effective date |
|--------------------------|-----------------|------------------|

Section 2 Account holder information

| | | | | |
|---------------------|------|------------------|------------------------------------------|------------------------------------|
| * First name | M.I. | * Last name | * Date of birth | * Membership identification or SSN |
| * Email address | | * Contact number | * Medicare number (if applicable) | |
| * Mailing address | | * City | * State | * ZIP |
| * Employer | | | * Group identification number (if known) | |
| Name of health plan | | | | |

Section 3 Eligible dependents

| | | | | | |
|---|--------------|-------------|------------------------------------------------------------------|--------------------------|-----------------|
| 1 | * First name | * Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | * Social Security number | * Date of birth |
| 2 | * First name | * Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | * Social Security number | * Date of birth |
| 3 | * First name | * Last name | <input type="checkbox"/> Male <input type="checkbox"/> Female | * Social Security number | * Date of birth |

Section 4 Benefit account

| | | | | |
|-------------|-------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------|-----------------------------|
| HRA account | <input type="checkbox"/> Employee only <input type="checkbox"/> Employee plus one <input type="checkbox"/> Family | Waive participation | <input type="checkbox"/> This year <input type="checkbox"/> Permanently | * Effective date (MM/DD/YY) |
|-------------|-------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------|-----------------------------|

Section 5 Reimbursement (for explanations, please review page 2)

| | | | | | | |
|----------------|-------------------------------------------------------------|--|-----------------------------------------------------------------------|-----------|-----------------------------------------------------------------------------------------------|--|
| Benefits card | <input type="checkbox"/> I would like a Benefits MasterCard | | <input type="checkbox"/> I already have a Benefits MasterCard | | <input type="checkbox"/> I would like a Benefits MasterCard card for my dependent over age 18 | |
| | Dependent's first name | | Dependent's last name | | Dependent's identification number or SSN | |
| Direct deposit | <input type="checkbox"/> Enroll me in direct deposit | | <input type="checkbox"/> Checking <input type="checkbox"/> Savings | Bank name | | |
| | Routing number | | Account number | | | |

Section 6 Authorization

| | |
|---------------------------------------------------------------------|------------------|
| I have read and agree to the terms and conditions on pages 1 and 2. | |
| * Employee signature X | * Signature date |

Please return to your human resources or benefits department upon completion.
 Questions? Contact BenefitHelp Solutions at 888-398-8057.

Benefits MasterCard

The Benefits MasterCard provides direct access to your flexible spending account (FSA), allowing you to pay for eligible health care expenses at qualified locations where MasterCard™ is accepted. When you use your Benefits MasterCard, you no longer have to pay for eligible expenses out of your pocket and wait for reimbursement. The money is deducted directly from your FSA account at the time of purchase. You may need to submit supporting documentation for certain purchases.

When using your Benefits MasterCard at pharmacies, simply swipe your card first and choose “Credit” if asked. The card is a smart card that will only pay for IRS-eligible FSA purchases. The store clerk will ask you for another form of payment to pay for your other purchases. You then pay for the non-FSA-eligible items with another card, cash or check. Your IRS-eligible purchases are automatically approved and paid directly from your FSA account. That's it — no claim forms to submit!

When paying for services provided by a medical, dental or vision provider, the Benefits MasterCard can automatically approve services that match a set copay or a multiple of that copay (not a percentage coinsurance) from your group health plan(s). Supporting documentation for these services is not needed. If the provider's charge is not a copay, you can still use the Benefits MasterCard and benefit from having the expense directly deducted from your account. For expenses that do not match the copay, you will need to submit supporting documentation. In some situations, your card will automatically be approved even if it is an ineligible expense. This most often happens when paying for services incurred in a prior plan year or for services where you coincidentally owe a multiple of the copayment. It is your responsibility to use your Benefits MasterCard only for eligible expenses.

Direct deposit

By having your healthcare reimbursement arrangement (HRA) reimbursement directly deposited into your bank account, you eliminate the hassle of having to go to the bank each time you receive a check. Instead of receiving a reimbursement check in the mail, you will receive a direct deposit remittance advice. The remittance advice will indicate the date your claim was paid, the amount that will be deposited to your bank account, and an explanation of benefits (EOB). All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take up to five (5) business days to appear in the designated account. Should you make any changes to your bank account, such as account closure or change in account number, please notify BenefitHelp Solutions immediately. If there is an interruption in the direct deposit service, you will receive checks for reimbursement claims paid during that time. You may cancel participation in the direct deposit program at any time.

Terms and Conditions

By signing this application:

1. **Acceptable plan terms.** You agree to abide by the terms, conditions and provisions of the plan contained in your employer's plan documents. These documents are available to you through your human resources or benefits department.
2. **Responsibility.** You acknowledge that the Internal Revenue Code (IRC) permits claim reimbursement only for eligible expenses incurred after the effective date and prior to the termination date of your HRA account. You assume full responsibility for all taxes, penalties, interest or other consequences that may be assessed to you by any state, federal or other governmental taxing authority as a result of receiving reimbursement for a disallowed expense. You will only use your account to pay for eligible expenses incurred by yourself and/or your tax dependents. Expenses cannot be reimbursed by any other plan. If requested, you agree to provide appropriate supporting documentation within the requested time frame. You understand that you cannot change or revoke an election until open enrollment or during an applicable change in status.
3. **Plan modification.** You have been informed that the plan offered by your employer may be modified from time to time, and you agree that your employer may cancel or amend your plan according to the employer's independent judgment and discretion without your consent or prior notice.
4. **Forfeiture.** You understand that you must claim reimbursement for eligible expenses incurred during the plan year for which you were an active participant within the run-out period of the plan year (and grace period if applicable), as stated in your Summary Plan Document. If any unused amounts remain in your account(s) after any applicable carryover, these amounts will be forfeited.
5. **Benefits MasterCard.** If it is determined that the Benefits MasterCard paid for an ineligible expense, you will either refund your account the amount of the ineligible expense or offset the ineligible expense with an eligible expense. If you fail to do so, the ineligible amounts may be included as taxable income at the end of the year. You understand that if you do not provide supporting documentation as required, your Benefits MasterCard may be deactivated until your account is settled.
6. **HSA contributions.** You understand that if you, your spouse or your children participate in an HSA plan, HSA contributions may be disallowed if any HSA participants also participate in the HRA account.