

Change Reasons: Rehired Employee • Marriage • Legal Separation • Divorce • Dependent Change •
• Direct Deposit Change • Other Change •

Reason for Application: _____ Date of Event: _____

Employer Name: _____

Member ID: _____ **Phone #:** _____ - _____ - _____

Your Social Security Number or your unique ID Number assigned by your program sponsor.

Name: _____
Last First M.I.

Address: _____
Street Apt.

City State Zip

Email Address: _____

Member DOB: ____/____/____ Do you have Medicare? If yes, enter your Medicare #: ____-____-____
Date of Birth (MM/DD/YY)

Please list your HRA eligible dependents below.

Dependent 1: _____
Last First M.I. Gender Social Security Number Date of Birth (MM/DD/YY)

Dependent 2: _____
Last First M.I. Gender Social Security Number Date of Birth (MM/DD/YY)

Dependent 3: _____
Last First M.I. Gender Social Security Number Date of Birth (MM/DD/YY)

Elected Coverage Single Employee Plus One Family **Effective Date:** ____/____/____

Benefits Card Yes, enroll me in a Benefits MasterCard. A Benefits MasterCard pays directly from your HRA at the point of service. (See page 2 for more details.)

Yes, please order a Benefits MasterCard for my dependent(s) named above: Dep 1 Dep 2 Dep 3

Direct Deposit will electronically deposit your reimbursement to your bank account.

Direct Deposit Yes, enroll me in Direct Deposit. Checking Savings **Name of Bank:** _____

Transit Routing # (First 9 digits on the bottom of your check) Account #

Yes, I authorize BenefitHelp Solutions to share my Protected Health Information (PHI) information with:

Protected Health Information Authorization **Name:** _____ **Relationship:** _____
Last First

For the purpose of: Any and all information Only eligibility and balance info Only claim status info

Participant Authorization

I have read and agree to the terms and conditions on pages 1 and 2.

Employee Signature _____ **Date** _____

BENEFITS CARD

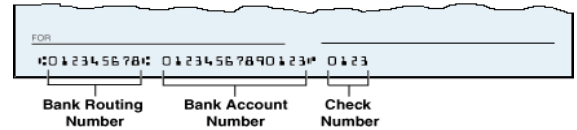
The Benefits Card provides direct access to your Health Reimbursement Arrangement (HRA) account, allowing you to pay for eligible health care expenses at qualified locations wherever MasterCard™ is accepted. When you use your Benefits Card, you no longer have to pay for eligible expenses out of your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

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

When paying for services provided by a medical, dental, or vision provider, the Benefits Card 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; however, if the provider's charge is other than a copay you can still use the Benefits Card and benefit from having the expense directly deducted from your account, you will just need to submit supporting documentation.

DIRECT DEPOSIT

By having your 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 two (2) 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 any reimbursement claims paid during that time. You may cancel participation in the direct deposit program at any time.



PHI - Authorization to Release Reimbursement Account Information to Family Members or Designated Individuals

By completing the Protected Health Information Authorization section and signing this application, I hereby authorize the use and disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to BenefitHelp Solutions. Any uses or disclosures already made with my permission cannot be taken back. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected under federal law. Information obtained or disclosed with this authorization will be limited to the minimum information needed to achieve the purpose.

IRS AND OTHER REQUIRED TERMS & CONDITIONS

- ACCEPTABLE HRA PLAN TERMS:** I agree to abide by the terms, conditions and provisions of the Plan contained in the Company's Plan Document. I acknowledge my right to examine the Plan Document or obtain a copy from my Human Resources department.
- RESPONSIBILITY:** I acknowledge that the Internal Revenue Code permits me to claim reimbursement only for my tax deductible expenses incurred after the effective date of my HRA elections and I assume full responsibility for all taxes, penalties, interest or other consequences which may be assessed to me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursement from the HRA for disallowed expenses. I will only use my account to pay for eligible Internal Revenue Code (IRC) § 213d health care expenses for myself and/or my tax dependents. Expenses cannot be reimbursed by any other plan. If requested, I will provide appropriate supporting documentation within the specified time frame.
- PLAN MODIFICATION:** I have been informed that the HRA offered by my employer may be modified from time to time and I agree that my employer may cancel or amend the HRA according to their independent judgement and discretion without my consent or prior notice to me.
- BENEFITS CARD:** If it is determined that the Benefits Card paid for an ineligible expense, I will either refund my account the amount of the ineligible expense or offset the ineligible expense with an eligible expense. I understand that if I do not provide supporting documentation as required, my Benefits Card may be deactivated until my account is settled. By declining to order a Benefits Card at Open Enrollment or when first offered, I may not be able to order one until the next Open Enrollment period.
- HSA CONTRIBUTIONS:** I understand that if my children, spouse, or I participate in an HSA Plan, HSA contributions may be disallowed if any HSA Participants also participate in the Health Reimbursement Arrangement Account.