

Power of Attorney Form

46770436 (12/18)



PLEASE PRINT CLEARLY

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

Section 1 Account holder information

* Consumer first name	M.I.	* Last name	* Date of birth ____ / ____ / _____	* Social Security number	
* Mailing address			* City	* State	* ZIP
* Physical address			* City	* State	* ZIP
* Email address			* Contact phone number		
* Employer					

Section 2 Attorney-in-fact information

* Power of attorney first name	M.I.	* Last name	* Social Security number
--------------------------------	------	-------------	--------------------------

Section 3 Attorney-in-fact authorization

BenefitHelp Solutions is hereby authorized to recognize the signature subscribed below in the payment of funds or transactions of any business from this account. All transactions shall be governed by applicable laws and the BenefitHelp Solutions Custodial Agreement. BenefitHelp Solutions will require the named attorney-in-fact to provide information as authentication if/when requesting information via an account specialist representative.

To the extent allowed by law, this authorization shall survive the account owner's disability or incapacity, and remain in effect until BenefitHelp Solutions' written notice of revocation and has a reasonable opportunity to act on such notice, or this authorization will cease upon death of the account owner.

* Signature of attorney-in-fact	* Date
---------------------------------	--------

***This form is not valid unless both the account holder and attorney-in-fact signatures are obtained and obtained on the same date.**

Return the completed form to BenefitHelp Solutions

Mail: BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108 **Fax:** 855-778-9837

Questions? Contact BenefitHelp Solutions at 855-378-0197, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Power of Attorney Form

46770436 (12/18)



PLEASE PRINT CLEARLY

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

Section 4 Account holder signature

By signing below, I authorize the attorney-in-fact identified above to perform any act I may perform pursuant to my account agreement with BenefitHelp Solutions. This authorization includes, for example, the ability to: (1) endorse, cash, or deposit checks or other items payable to my order; (2) withdraw funds from this account via any means allowed for this account (including, but not limited to, debit card, Internet transactions, wire transfers, etc.); and (3) give you instructions for the handling of any and all matters in connection with this account. I understand the powers I give to my attorney-in-fact, and any limitations on those powers are between the attorney-in-fact and me, even if BenefitHelp Solutions has expressed written notice of those powers. For example, if I only give my attorney-in-fact authority to pay my bills and my attorney-in-fact exceeds that authority, BenefitHelp Solutions is not responsible for that breach of authority. I agree to hold BenefitHelp Solutions harmless and be solely responsible for any and all damages or costs, without limitation, that BenefitHelp Solutions incurs due to BenefitHelp Solutions reliance on this power of attorney.

* Signature of account holder	* Date
-------------------------------	--------

***This form is not valid unless both the account holder and attorney-in-fact signatures are obtained and obtained on the same date.**

NOTARY SIGNATURE

On this _____ day of _____, 20____, before me appeared, _____ who, being duly sworn, did say that he/she is the account holder named in the foregoing power of attorney form.

Notary public	Commission expiration date
---------------	----------------------------

(Notary public stamp or seal)

Section 5 Revocation of power of attorney

I hereby revoke the appointment of the above-named attorney-in-fact and have notified them of this change. I understand the HealthCare Bank may charge the account for the amount of any request or pre-authorized transactions dated on or before this date if they have been authorized by my attorney-in-fact.

* Signature of account owner	* Date
* Signature of attorney-in-fact	* Date

Return the completed form to BenefitHelp Solutions

Mail: BenefitHelp Solutions, P.O. Box 2823, Fargo, ND 58108 **Fax:** 855-778-9837

Questions? Contact BenefitHelp Solutions at 855-378-0197, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.