VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN
EMPLOYEE ENROLLMENT/CHANGE FORM - Page 1

- Use this form to enroll in the RHS Plan or to make any changes to your existing RHS Plan account.
- Read the instructions on the back before completing the form. Please use blue or black ink.
- Please check all applicable boxes:

☐ New Enrollment

Type of Change:

☐ Change in Name (Please attach legal document) ☐ Change in Marital Status ☐ Change in Survivor

☐ Change in Address ☐ Change in Work Information

1 Essential Information

Employer Plan Number 8 _ _ _ _ _ _ Employer Name _____ State _____

Participant Name (Last, First and Middle Initial) _____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

2 Participant Personal Information

Mailing Address

Street _____

City _____

State _____ Zip Code _____

Evening Phone Number

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Area Code

Email Address _____

Gender ☐ Female ☐ Male

Marital Status ☐ Married ☐ Single

Date of Birth

___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Date Employed

___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

3 Work Information

Job Title _____

Daytime Phone Number

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
Area Code

4 Survivor Information (Note: Please read the instructions.)

Survivors

Spouse Name _____ SSN ___ - ___ - ___ Date of Birth _____

Dependent Name _____ SSN ___ - ___ - ___ Date of Birth _____

Dependent Name _____ SSN ___ - ___ - ___ Date of Birth _____

Dependent Name _____ SSN ___ - ___ - ___ Date of Birth _____

Dependent Name _____ SSN ___ - ___ - ___ Date of Birth _____

☐ Additional survivor information on attached sheet

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL TO YOUR EMPLOYER

(continued on back)

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5 Authorized Signatures

For new enrollments:

- I acknowledge that I have received and read the current disclosure documents, including any applicable prospectuses prior to investing in any funds.
- I understand that I will not be permitted to choose to cease participation so long as I am a member of the covered group.

For all enrollments and changes:

- I acknowledge that I have read the instructions for the RHS Plan Employee Enrollment/ Change Form. I understand that the ICMA Retirement Corporation has established required procedures for telephone and Internet transfers that include personal identification numbers, recorded instructions, and written confirmations. In the event I choose to transfer funds by telephone or Internet, I agree that neither the ICMA Retirement Corporation, nor ICMA-RC Services, LLC, will be liable for any loss, cost, or expense for acting upon any telephone or Internet instructions believed by it to be genuine and in accordance with the required procedures.
- If applicable, I understand that the availability of benefits for domestic partners, same sex spouses, and civil unions varies by state and that the tax treatment of RHS reimbursements in these situations may also vary.
- I understand that upon my death, my account will be transferred to my spouse and/or other qualifying dependents for tax-free reimbursement of qualifying medical expenses. If I am not survived by a spouse or any dependents, my account balance will return to my employer's RHS trust.

_____ _____

Participant Signature Date

6 Employer Use Only

_____ _____

Employer Signature Date

Is the employee currently eligible to receive benefits from the RHS Account under Section IX of your RHS Plan Adoption Agreement? ☐ Yes* ☐ No

If yes, what date did the employee become eligible? ___ ___/___ ___/___ ___ ___ ___
Month Day Year

☐ Eligibility date entered in EZLink (see Chapter 4 of the RHS Plan Employer Manual).

*** If yes, the Participant should also complete the *RHS Plan Employee Eligibility Form* for Meritain Health, Inc.**

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