INSTRUCTIONS for completing the EMPLOYEE ENROLLMENT FORM

This form can be completed electronically or can be printed out and filled in manually. If you complete the form electronically, you must print it, sign it and then submit it (this form cannot be saved to your computer). If you complete this form manually (hand written), please print (no cursive) your information legibly.

1. Employee Demographic Information

Check the appropriate box to let us know if your demographics have changed. We will not update your demographics unless you have indicated that there have been changes. The required fields are:

Name
Mailing Address (this is where important plan information and your CBI FlexCard (if applicable) will be mailed)
E-mail Address
Social Security Number
Date of Birth

2. Purpose and Important Dates

This form can only be used for one of the following purposes:

1. New Plan-year Election - select when re-enrolling in a plan
2. Demographic Update - select when making a demographic change such as an email or mailing address
3. Add Dependent - select when adding a dependent to your plan
4. Remove Dependent - select when removing a dependent from your plan
5. New Hire - select when enrolling in a plan for the first time. All fields required.
6. Termination - select when ceasing enrollment in a plan. Termination date required.
7. Election Change - select if making a plan election change. You must provide an IRS approved reason for making the change. Effective date of change required. Your new election cannot be less than your payroll contributions to date. This amount can be obtained from your HR department.

3. Dependent Information - Only needed for enrolling in an HRA or for ordering a CBI FlexCard

In this section, indicate which dependents, including a spouse, that you would like to enroll in your HRA (if applicable) or for whom you would like to order a CBI FlexCard (if applicable). CBI will not allow your spouse or dependents to access your personal information unless you indicate that they have Authorized Account Access. Social Security Numbers and gender are required for Medicare reporting purposes.

4. Salary Reduction Plans

In this section, indicate which salary reduction plan(s) in which you would like to enroll, terminate, or make changes. The IRS has capped the election for these plans as described below. Salary reduction plans include:

- Health FSA-Medical Reimbursement Accounts (Health FSA-MRA) - IRS Cap for 2014 = $2,500
- Limited Use Medical Reimbursement Accounts (LUMRA) - IRS Cap for 2014 = $2,500
- Dependent Care Accounts (FSA-DCA) - IRS Annual Cap for 2014 = $5,000 (family)
- Qualified Parking Expense Accounts (QPE) - IRS Monthly Cap for 2014 = $250
- Qualified Transportation Expense Accounts (QTE) - IRS Monthly Cap for 2014 = $130
- Health Savings Accounts (HSA) - IRS Annual Cap for 2014 = $3,300/Individual; $6,550/Family

Check with your employer as to which plans are offered and whether or not you are eligible. Select the appropriate box if you do not intend to enroll in any offered plan. Select the appropriate box if you would like to have your applicable insurance premiums deducted from your pay on a pre-tax basis (your employer may use a separate form to handle insurance premium payroll deductions).

Your election per pay period times the number of pay periods MUST equal your total annual election. Please check your math.

5. Health Reimbursement Arrangements (HRA) - to be completed by the Employer only

FOR EMPLOYERS ONLY - In this section, indicate which HRA your employee is to be enrolled. If this is a mid-plan year entry, be sure the contribution amount provided reflects any necessary prorations.

6. Read Carefully

Please carefully read the paragraph in this section before signing.

7. Sign and Date

Both employee and employer signatures are required for any salary reduction plan. Only the employer signature is needed for HRA enrollments. Be sure to include the date.

Submitting the Employee Enrollment Form

EMPLOYEE- Deliver to your HR Department.
EMPLOYER- Submit via one of the following methods: 1) Go to https://conceptsinbenefitsinc.box.com/hipaasecure for instructions on to send [HIPAA secure]. 2) Fax to: 603-472-3281.

EMPLOYEE ENROLLMENT FORM

Print Form

Employer Name: Division (if applicable)

1. Employee Demographic Information

☐ My demographics have not changed ☐ My demographics have changed - changes are included in this section

Name email

Mailing Address Phone # SSN

City State Zip Alternate Phone #

Medicare Beneficiary (HRA ONLY) ◯ Primary ◯ Secondary ◯ ESRD Date of Birth ◯ Male ◯ Female

2. Purpose and Important Dates

◯ New Plan-year Election
◯ Demographic Update
◯ Add Dependent
◯ Remove Dependent

◯ New Hire Date of Hire Effective Date Date of first payroll deduction (required for DCAP, QTE, and QPE)

◯ Termination Date of Termination Benefit end Date (HRA Only)

◯ Election Change

Effective Date of Change

IRS Reason for change*

◯ Marriage
◯ Divorce/Legal Separation
◯ Add New Dependent
◯ Death of Spouse/Dependent
◯ Loss of "Dependent" Status
◯ Medicare Entitlement
◯ Daycare Cost Change
◯ Change in Daycare Provider
◯ Spouse Becomes Unemployed
◯ Spouse Became Employed
◯ Spouse - Change in Job
◯ Change in job classification (part/full time)
◯ Change in Residence (DCAP only)
◯ Qualified Medical Child Support Letter
◯ Leave of Absence (LOA)
◯ Other - Please explain (may not qualify per IRS regs)

* Reason not required for election changes for Qualified Transportation and Parking plans.

3. Dependent Information - Only needed for enrolling in an HRA or for ordering a debit card (use additional form to add more dependents)

Dependent #1 Date of Birth ☐ Order CBI FlexCard ☐ Authorized Account Access Medicare Beneficiary - HRA Only ◯ Primary ◯ Secondary ◯ ESRD
SSN SSN only needed if enrolling in an HRA ◯ Male ◯ Female

Dependent #2 Date of Birth ☐ Order CBI FlexCard ☐ Authorized Account Access Medicare Beneficiary - HRA Only ◯ Primary ◯ Secondary ◯ ESRD
SSN SSN only needed if enrolling in an HRA ◯ Male ◯ Female

Dependent #3 Date of Birth ☐ Order CBI FlexCard ☐ Authorized Account Access Medicare Beneficiary - HRA Only ◯ Primary ◯ Secondary ◯ ESRD
SSN SSN only needed if enrolling in an HRA ◯ Male ◯ Female

4. Salary Reduction Plans

☐ I choose not to enroll in the offered salary reduction plan(s) ☐ I authorize eligible insurance premium pre-tax contributions (POP)

Plan #1 Election per pay period # of pay periods Total Annual Election Employer Contribution

Plan #2 Election per pay period # of pay periods Total Annual Election Employer Contribution

Plan #3 Election per pay period # of pay periods Total Annual Election Employer Contribution

5. Health Reimbursement Arrangements (HRA) - to be completed by the Employer only

Plan #1 Medical Plan Level Employer Contribution Amount

Plan #2 Medical Plan Level Employer Contribution Amount

6. Read Carefully

I understand that the choice I have indicated above will stay in effect for the remainder of the plan year, unless I have a qualifying change in my family status. I also understand that the amounts specified or implied above will reduce my pay in equal installments (except for the HRAs). Should the amount represented by my choices as indicated above exceed my gross wages for any given pay period, I authorize my employer to carry forward the balance and recoup the balance and any prior outstanding balance from subsequent pay periods. I also authorize my employer to deduct the balance through the current month from my final pay check in the event I terminate employment. I understand that details on how the plan works, restrictions and other considerations can be found in the Summary Plan Description (SPD) which is available through my employer. I also understand that I must save receipts for all expenses in the event they are requested to substantiate a claim.

7. Sign and Date

Employee Signature: Date:

Employer Signature: Date:

Concepts in Benefits, Inc. • 43 Constitution Drive • Bedford New Hampshire 03110
866.672.2400 • 800.224.7688 • Fax 603.472.3281 • www.conceptsinbenefits.com • enrollments@conceptsinbenefits.com