P.O. Box 43653 Louisville, KY 40253-0653 (502) 244-1161 (800) 919-BMSI FAX (502) 244-1162 *www.bmsllc.net*

ELECTION FORM FOR THE HEALTH REIMBURSEMENT ARRANGEMENT (COMP HRA)

PLEASE COMPLETE ALL FIELDS ON THE FORM AND PRINT CLEARLY AND LEGIBLY

Employer ________________________________ Employee Name ____

Social Security # ____ Date of Birth ________________________

Home Address ____ City ______________ State __________ Zip __________

Home Phone (______) __________________________ E-mail Address ____

Debit Card Information for Participants: I understand that an HRA Debit Card will be ordered for me based on the election(s) indicated below. NOTE: I agree to use the Debit Card for only qualified medical expenses. I understand that qualified expenses paid with the card cannot be reimbursed by any other plan and that I will not seek reimbursement for expenses paid with the card from any other source. I also understand that if a payment is made that is not for qualified expenses under IRS guidelines, or if I fail to provide adequate documentation to substantiate a Card swipe, I will repay the Plan. If I fail to reimburse the Plan, I authorize the Plan Sponsor to withhold such non-qualified expenses, including taxes, penalties, fines, or surcharges, from my payroll to the extent permitted by law. I also understand that I am responsible for submitting all requested receipts to BMS to validate my card usage as required under IRS guidelines. Usage of the Debit Card at a qualified merchant does not negate the need to submit receipts per current IRS rules and regulations if requested and necessary. I agree to review my account online periodically at www.bmsllc.net to obtain information on open transactions that are in need of substantiation. I realize that if I fail to respond to request for receipts within 60 days of the posting of the transaction, my Debit Card will be suspended. Full compliance and submission of required receipts will be necessary in order to reactivate my Card. Notification of open transactions will be *emailed* to the email address provided above or saved at my employee website at www.bmsllc.net. Also, the debit card agreement that is sent to me with my card outlines the individual participant's responsibility for proper use. *A valid e-mail address is a highly recommended for card use in order to be notified of items in need of receipts.* ***EXTRA CARDS:*** *If you wish to order extra cards for your spouse and/ or dependents, please visit your employee website at www.bmsllc.net or contact BMS after the start of the Plan Year. Must be for a qualified dependent under IRS rules and regulations. A fee of $1.50 per additional card issued will be deducted from your HRA.* **IMPORTANT: Before using a card, a participant must follow the instructions on the Card sticker to activate the card. If the card is not activated, transactions will decline at the point of sale.**

HRA BENEFIT PLAN COVERAGE ELECTIONS

Single - HRA Benefit Amount____________________ **Employee+Child(ren) - HRA Benefit Amount______________

****Employee+Spouse-HRA Benefit Amount______________________ **FAMILY**HRA Benefit Amount_____________**

** COVERED MEMBERS. ALL INFORMATION IS REQUIRED FOR HRA ENROLLMENT. **

Use a separate sheet if additional dependents are to be covered.

1. Covered Dependent (or Spouse) Full Name ____ Gender _________

Social Security Number _____________________________ Date of Birth ___________ Relation to Employee ___________

Medicare HICN # (if applicable) _________________ Does this dependent have End Stage Renal Disease? ________

2. Covered Dependent (or Spouse) Full Name ____ Gender _________

Social Security Number _____________________________ Date of Birth ___________ Relation to Employee ___________

Medicare HICN # (if applicable) _________________ Does this dependent have End Stage Renal Disease? ________

3. Covered Dependent (or Spouse) Full Name ____ Gender _________

Social Security Number _____________________________ Date of Birth ___________ Relation to Employee ___________

Medicare HICN # (if applicable) _________________ Does this dependent have End Stage Renal Disease? ________

HRA WAIVER/DECLINING COVERAGE

___________ (PLEASE INITIAL)

I have declined the option to enroll in my employer sponsored HRA benefit for this plan year and understand that I will not be eligible to participate or be reimbursed monies for medical expenses from the HRA.

The HRA will reimburse up to the specified amount detailed in the my employer's Summary Plan Description and based upon my employer's plan design. I understand that the monies reimbursed under the HRA are provided by my employer for the purpose of medical expenses and that the benefit is free from federal, state and FICA taxation change. My employer and I agree the benefit election set forth above is accurate and that qualified medical expenses eligible as outlined in the Health Reimbursement Arrangement plan design will be paid on a tax-free basis. I understand that I may change my election in the event of certain changes in my status and that, prior to the first day of each Plan Year; I will be offered the opportunity to change my benefit election for the upcoming Plan Year. I acknowledge that I have received, read and understand the Summary Plan Description. I have also read and understand the Important Information provided with enrollment materials.

Employee Signature: ____ Date ______________________

MUST BE COMPLETED BY EMPLOYER	Date of Hire (mm/dd/yy) ___/____/_____ Effective Date of Participation (mm/dd/yy) _____/_____/________ Pay Cycle _________ Dept_____________