



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 Address

Change in Marital Status

Change in Work Information

Change in Survivor

Change in Beneficiary

1 Essential Information

| | | |
|---|---------------------|------------------------------|
| Employer Plan Number _____ | 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 _____ <table style="width:100%;"> <tr> <td style="width:50%;"> Gender <input type="checkbox"/> Female <input type="checkbox"/> Male </td> <td style="width:50%;"> Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single </td> </tr> </table> | Gender <input type="checkbox"/> Female <input type="checkbox"/> Male | Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single |
| Gender <input type="checkbox"/> Female <input type="checkbox"/> Male | Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single | | |
| Date of Birth ____/____/____ Month Day Year | Date Employed ____/____/____ Month Day Year | | |

3 Work Information

| | |
|-----------------|--|
| Job Title _____ | Daytime Phone Number (_____) _____ - _____ Area Code _____ |
|-----------------|--|

4 Survivor and Beneficiary Information (Note: Please read the instructions. Only individuals should be named as beneficiaries. Do not name a trust or your estate.)

Survivors

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

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

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

Additional survivor information on attached sheet

Primary Beneficiaries (Benefits will be available to Primary Beneficiary only if **NO** spouse or dependent lives longer than you.)

Name _____ SSN _____ - _____ - _____ Date of Birth _____ % of Benefits _____

Name _____ SSN _____ - _____ - _____ Date of Birth _____ % of Benefits _____

Additional primary beneficiary information on attached sheet

Contingent Beneficiaries (Benefits will be available to Contingent Beneficiary only if **NO** primary beneficiary lives longer than you.)

Name _____ SSN _____ - _____ - _____ Date of Birth _____ % of Benefits _____

Name _____ SSN _____ - _____ - _____ Date of Birth _____ % of Benefits _____

Additional contingent beneficiary information on attached sheet

(Residents of community property states please read instructions.)

(continued on back)

VANTAGECARE RHS PLAN EMPLOYEE ENROLLMENT/CHANGE FORM INSTRUCTIONS

By completing this form, you will supply the information necessary to begin participation in your employer's VantageCare Retirement Health Savings (RHS) program. You may also use this form to change the information at a later date.

Before you complete this form for enrollment, please read the accompanying literature so that you understand your plan's provisions.

Your employer's plan may require participation for all members of a covered group or may permit employees in the covered group to irrevocably elect to participate. If your employer's plan allows you to choose to participate, your completion of this form will serve as your election to participate. You do not need to complete the enrollment form until you wish to participate. Once you elect to participate in the RHS plan, you may not cease participation at any time. To determine whether your employer requires participation or permits you to elect participation, please review your employer's RHS Announcement Letter or contact your employer's benefits office.

In order for ICMA-RC to process your enrollment/change efficiently, please complete the form accurately and completely and submit it to your employer. Please be sure to keep a copy for your records of all forms and documentation you submit.

Always review your quarterly statements to confirm the accuracy of your enrollment information. If you discover a discrepancy, contact ICMA-RC Investor Services at 1-800-669-7400 as soon as possible.

Initial Enrollment/Type of Change - Please check either Initial Enrollment or each Type of Change that you are making in your account information. Keep in mind that once you are enrolled in the plan, you do not have the option of discontinuing your participation.

Please note that you may notify us of many changes in your account information by accessing your account at www.icmarc.org.

If you are eligible to receive benefits from your RHS account, and are making changes to your account information, please also contact Meritain Health, Inc., at 1-888-587-9441.

1. Essential Information - Please complete this section carefully. The information you submit will be used to establish your account and to identify the account when you make changes. The employer plan number is available from your employer. If you are reporting a name change, please enter your new name into the "Name" line in Part 1, and provide your employer with any required documentation, which may include a copy of one of the following: Driver's License, Social Security card, marriage certificate or court order.

2. Participant Personal Information - The mailing information provided here will determine the address to which your ICMA-RC RHS account statement will be sent. If you are changing your marital status, you may wish to review your survivor and beneficiary information at this time.

3. Work Information - Please provide your job title and daytime phone number.

4. Survivor and Beneficiary Information - IMPORTANT - Upon your death, your account will be transferred to your surviving spouse and/or dependents for tax-free reimbursement of their medical expenses. If you do not have a surviving spouse or dependent(s), your account will be transferred to your designated beneficiary(ies) for taxable reimbursement of their medical expenses. The beneficiary(ies) you designate on this form will only have access to the account if you have no surviving spouse or dependents.

Surviving spouse and/or dependent(s): If a spouse and/or dependent(s) survive you, they will be able to use your remaining account balance for their own medical expenses on a tax-free basis. In this case, the beneficiaries you designate on this form will not be allowed to use the account balance. However, even if you currently have a spouse and dependents, it is important that you designate a beneficiary(ies) in case your circumstances change before your death. Otherwise, your remaining assets will return to your employer's RHS trust. If your account balance is not fully utilized upon the death of your surviving spouse and all dependents, the balance will be available to the designated beneficiary(ies) of the last survivor to die for taxable reimbursement of their medical expenses. If there is no such designated beneficiary(ies), or if we cannot locate the beneficiary(ies), the account balance will return to your employer's RHS trust.

No surviving spouse or dependents: If there are no surviving spouse and/or dependents upon your death, the beneficiary(ies) you designate will be able to use the remaining value of your account for taxable reimbursement of their medical expenses. If no primary beneficiary(ies) lives longer than you, your contingent beneficiary(ies) will be able to use the account. If none of your primary or contingent beneficiaries are living at the time of your death, or if you do not have a signed, valid beneficiary designation on file, or if we cannot locate your beneficiary(ies),

your remaining account balance will revert to your employer's RHS trust. If your account balance is not fully utilized upon the death of your designated beneficiary(ies), the balance will be available to the named beneficiary(s) of your beneficiary for taxable reimbursement of their medical expenses. If there is no such designated beneficiary(ies), or if we cannot locate the beneficiary(ies), the account balance will return to your employer's RHS trust.

Naming your beneficiary(ies):

- You may name only an individual(s) as your primary and contingent beneficiary(ies). Do not name your estate or a trust as these entities are not able to use the account for medical expense reimbursement.
- Remember that your spouse/dependents are automatically eligible to use the account for medical expenses if they survive you. You should not name your spouse as your beneficiary. You may name an individual(s) currently your dependent also as beneficiary to deal with the possibility that the individual(s) no longer qualifies as a dependent at your death. The named beneficiary will be able to use the account only if there are no surviving spouse or dependents.
- If you need to designate additional survivors, or primary and/or contingent beneficiaries, please do so on a separate sheet of paper.
- Remember, if you do not designate a beneficiary(ies), and you die without a surviving spouse or dependent(s), your account balance will revert to your employer's trust. It is important that you review your beneficiary designation regularly and revise it in case of a change in your circumstances.
- If you are a resident of a community property state (AZ, CA, ID, LA, NV, NM, TX, WA, or WI) and are married, your designation of a beneficiary other than your spouse does not constitute a waiver of your spouse's right to your RHS account assets upon your death. Your designated beneficiary will have access to the account only if you are not survived by a spouse or other qualifying dependents.
- Please be advised that the availability of benefits for domestic partners, same-sex spouses, and civil unions varies by state. The tax treatment of RHS reimbursements in these situations may also vary. Please consult your employer and/or tax advisor for more information.

5. Authorized Signatures - Once you have completed this form, sign it, make a copy for your records and submit it to your employer.

Your signature acknowledges that your initial enrollment will result in contributions initially allocated to the Vantagepoint Money Market Fund* or another chosen fund by your employer. All changes to your investment allocation for future contributions and transfers of fund balances may be made through VantageLine, Account Access, or an ICMA-RC Investor Services Representative. State law, local law, or your employer may place restrictions on available investments.

** Investments in the fund are not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. Although the Fund seeks to preserve the value of your investment at \$1.00 per share, it is possible to lose money by investing in the Fund.*

Please consult the Vantagepoint Funds Prospectus carefully for a complete summary of all fees, expenses, charges, financial highlights, investment objectives, risks and performance information. Investors should consider the Fund's investment objectives, risks, charges and expenses before investing or sending money. The prospectus contains this and other information about the investment company. Please read the prospectus carefully before investing. Vantagepoint Funds are distributed by ICMA-RC Services LLC, a wholly owned broker-dealer subsidiary of ICMA-RC and member NASD/SIPC. For a current prospectus, contact ICMA-RC Services, LLC by calling 800-669-7400 or by writing to 777 North Capitol Street, NE, Washington, DC 20002-4240, or by visiting www.icmarc.org.

Married residents of community property states: See instructions for Part 4 above.

6. Employer Use Only - Once the participant has completed this form for initial enrollment, please verify his/her eligibility to enroll by signing the form in Section 6 and enter the account information into EZLink. For changes in participant information, please enter the changes into EZLink.

If the participant is eligible to receive benefits from the RHS account immediately upon enrollment (i.e., the participant may use the account for qualifying medical expenses as allowed in Section IX of your RHS Plan Adoption Agreement), please provide the RHS Employee Eligibility Form to the employee and enter the benefit eligibility information into EZLink. See Chapter 4 of the VantageCare RHS Employer Manual for information.

Print the EZLink Confirmation Screen for your records.

Retain this form in your employee records.

