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

mployer Plan Number: 801081 Employer Plan Name: CITY OF OREM

ocial Security Number: ___ - __ - ____

ll Name of Participant: ____________________
Last First M.I.

2 Participant Personal Information

ailing Address/Street: ____________________

ity: ____________________ State: ____ Zip Code: _____ - ____

ate of Birth: __ / __ / ____ (mm/dd/yyyy) Date Employed: __ / __ / ____ (mm/dd/yyyy)

eferred Phone Number: (___) ___ - ____ Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single
Area Code

3 Work Information

b Title: ____________________ Email Address: ____________________

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

urvivors

pouse Name____________________ SSN___-___-___ Date of Birth____________

ependent Name ____________________ SSN___-___-___ Date of Birth____________

ependent Name ____________________ SSN___-___-___ Date of Birth____________

ependent Name ____________________ SSN___-___-___ Date of Birth____________

ependent 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

VANTAGECARE RETIREMENT HEALTH SAVINGS (RHS) PLAN EMPLOYEE ENROLLMENT/CHANGE FORM - Page 2

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

f 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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