MissionSquare RETIREMENT

MissionSquare Retirement Health Savings (RHS) Plan

Employee Enrollment/Change Form Instructions

By completing this form, you will supply the information necessary to begin participation in your employer's MissionSquare 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 requires participation for all members of a covered group. To determine whether you are a member of a covered group, please review your employer's RHS Plan Provisions or contact your employer's benefits office.

In order for MissionSquare Retirement 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 MissionSquare Participant Services at 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.missionsq.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 888-587-9441. Address changes are made with MissionSquare and are forwarded to Meritain Health.

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 MissionSquare RHS account statement will be sent. If you are changing your marital status, you may wish to review your survivor information at this time.

3. Work Information

Please provide your job title and daytime phone number.

4. Survivor 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 return to your employer's RHS trust.

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. If your account balance is not fully utilized upon the death of your surviving spouse and all dependents, 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, your remaining account balance will revert to your employer's RHS trust.

Naming your survivor(s):

- Remember that only your spouse/dependents are eligible to use the account for medical expenses if they survive you.
- If you need to designate additional survivors, please do so on a separate sheet of paper.
- 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 a diversified target-date fund based on your age or another fund chosen by your employer. All changes to your investment allocation for future contributions and transfers of fund balances may be made through MissionSquare's self-service phone line, Account Access, or an MissionSquare Participant Services representative. State law, local law, or your employer may place restrictions on available investments.

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 2 of the Retiree Health Program Employer Manual for information.

Print the EZLink Confirmation Screen for your records.

Retain this form in your employee records.

MissionSquare Retirement Health Savings (RHS) Plan

Employee Enrollment/Change Form

- 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 of Name *(must attach legal document)* ☐ Change in Marital Status ☐ Change in Survivor

☐ Change of Address ☐ Change of Work Information

1 ESSENTIAL INFORMATION

EMPLOYER PLAN NUMBER:	EMPLOYER PLAN NAME:
SOCIAL SECURITY NUMBER:	FULL NAME: *LAST, FIRST, MI*

2 PARTICIPANT PERSONAL INFORMATION

MAILING ADDRESS:

STREET *CITY* *STATE* *ZIP*

DATE OF BIRTH: *MM/DD/YYYY*	DATE EMPLOYED: *MM/DD/YYYY*	GENDER: ☐ Female ☐ Male	MARITAL STATUS: ☐ Married ☐ Single

PREFERRED PHONE NUMBER:	EMAIL ADDRESS:

3 WORK INFORMATION

JOB TITLE:	EMAIL ADDRESS:

4 SURVIVOR INFORMATION *(PLEASE READ THE INSTRUCTIONS)*

	SOCIAL SECURITY NUMBER	DATE OF BIRTH *MM/DD/YYYY*
Spouse Name:		
Dependent Name:		
Dependent Name:		
Dependent Name:		
Dependent Name:		

☐ Additional survivor information on attached sheet

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

MissionSquare Retirement ■ Attn: Workflow Management Team ■ P.O. Box 96220 ■ Washington, DC 20090-6220 ■ Toll Free 800-669-7400 ■ www.missionsq.org ■ Fax (202) 682-6439 53367-1121-RHSENROLL

EMPLOYER PLAN NUMBER:	SOCIAL SECURITY NUMBER:

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 MissionSquare Retirement 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 MissionSquare Retirement, nor MissionSquare Investment Services, 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: *MM/DD/YYYY* ______________

6 EMPLOYER USE ONLY

Employer Signature: ______________________ Date: *MM/DD/YYYY* ______________

Name and Title *(Please Print)*: ______________________

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? *MM/DD/YYYY* ______________

☐ Eligibility date entered in EZLink *(see Chapter 4 of the Retiree Health Program Employer Manual)*.

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

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