



EMPLOYEE INFORMATION PACKET

MEDICAL CENTER

NAME _____ AGE _____
ADDRESS _____ DATE _____

R **What is an FSA?**

An FSA is a Flexible Spending Account plan that allows you to use tax-free income to pay for your family's out of pocket medical and dependent care expenses.

You just set aside some of your gross salary to pay for current qualified medical and child care expenses and...

The money you put in the plan is exempt from tax...
FOREVER!

☐ LABEL
REFILL 0 1 2 3 4 5 PRN NR

SIGNATURE _____

It's **EASIER** than you think!



Benefit Advantage

HOW IT ALL WORKS

Health Care Flexible Spending

The Health Care FSA gives you the benefit of allocating money pre-tax to reimburse you for out-of-pocket medical expenses for you and your dependents during the plan year. Dependents include your spouse, children residing with you, or a parent for whom you claim on your taxes as a dependent. You do not need to participate in your Company's group insurance plan in order to participate in the Health Care Flexible Spending Account.

Prior to the beginning of each plan year, you may elect how much you want to contribute to the plan. Throughout the plan year equal payroll deductions will be taken from your pay before Federal, State, and Social Security taxes are assessed. The deduction will then be deposited into your Flexible Spending Account(s). You must complete, sign, and date your election form by the deadline set by your employer.

Election Limit

Your election limit is set by your employer.

Incurring Expenses

As you incur eligible expenses, you will complete and send to Benefit Advantage a reimbursement request form itemizing your expenses with supporting documentation. The expenses must be for services incurred during the current plan year. You will have a run off period after the close of the plan year to submit your requests for expenses incurred during the previous plan year. Please refer to your Summary Plan Description (SPD) for limits on your plan.

Documenting Your Expenses

All documentation included with your claim form must have the following listed; Date of Service, Description of Service, Patient Name, Provider Name and Patient Responsibility. Statements from your provider that list codes for a description are not valid documentation.

Over The Counter (OTC)

OTC items must be supported by a prescription or Letter of Medical Necessity.

Reimbursements

All qualified claim requests will be processed and issued to you within 5 business days. Payment will be issued directly to the participant. It is the responsibility of the participant to forward these funds on to their provider if necessary. Benefit Advantage will not send any funds to the provider.

Health Care Account

You may be reimbursed your entire annual Health Care FSA Election at any time during the plan year after you have incurred the expense. Any unspent dollars up to \$500 at the end of the plan year will be carried over to the subsequent plan year. Unspent dollars over the allowable \$500 carryover at the end of the plan year are forfeited.

Termination

If your employment terminates during the plan year, you may only submit claims incurred up to your termination date. You will have a submission period to submit claims; please refer to your SPD for time limit.



Benefit Advantage

HOW IT ALL WORKS

Dependent Care Account

The IRS states an eligible dependent is less than 13 years old and living with you. An eligible dependent may also include your mentally or physically impaired spouse/dependent/child that is living with you and incapable of caring for him or herself.

To be eligible to participate in this account all of the following must apply:

1. The expenses must be necessary to allow you and your spouse to work or to seek employment.
2. These providers **must** declare the funds you pay them as income.

Eligible providers include:

- Child care centers
- Family day care providers
- Babysitters
- Nursery schools (this does not include tuition for kindergarten)
- Caregivers for disabled dependent or spouse who lives with you.

The IRS states the annual maximum amount a family may withhold in a dependent care plan is the lesser of \$5,000 per family, your income or your spouse's income. A single parent is eligible for this program with the above limitations.

If you and your working spouse have dependent care accounts with your employers, the maximum combined contribution allowed by the IRS is \$5,000. Married individuals filing separate tax returns can each claim a maximum of \$2,500 through a flexible spending account.

If you are married and your spouse is a full-time student or unable to care for him or herself, you may claim \$2,400 if you have one (1) dependent or \$4,800 if you have more than one dependent.

Dependent Care expenses are reimbursed up to the cash balance in your account.

Unpaid claims are reimbursed as more money is credited to your account.



Benefit Advantage

Mail: PO BOX 5546 DePere, WI 54115-5546
Phone: (800) 686-6829
Fax: (920) 339-0038

Know Your Health Care FSA Eligible and Ineligible Expenses

Maximize the Value of Your Reimbursement Account - Your Health Care Flexible Spending Account (FSA) dollars can be used for a variety of out-of-pocket health care expenses. The following is based on a list of eligible and ineligible expenses used by federal employees.

Eligible Expenses

BABY/CHILD TO AGE 13

- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby /Well Child Care

DENTAL

- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

EYES

- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

HEARING

- Hearing Aids and Batteries
- Hearing Exams

LAB EXAMS/TESTS

- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

MEDICAL EQUIPMENT/SUPPLIES

- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

MEDICAL PROCEDURES/SERVICES

- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

MEDICATIONS

- Insulin
- Prescription Drugs

OBSTETRICS

- Breast Pumps and Lactation Supplies
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

PRACTITIONERS

- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

THERAPY

- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact Benefit Advantage, Inc. at 800-686-6829.

The IRS does NOT allow the following expenses to be reimbursed under Health Care FSAs, as they are not prescribed by a physician for a specific ailment.

Ineligible Expenses

- | | | |
|--------------------------------------|---|--------------------------------|
| ■ Contact Lens or Eyeglass Insurance | ■ Insurance Premiums and Interest (FSA Ineligible Only) | ■ Personal Trainers |
| ■ Cosmetic Surgery/Procedures | ■ Long Term Care Premiums (FSA Ineligible Only) | ■ Sunscreen (spf less than 30) |
| ■ Electrolysis | ■ Marriage or Career Counseling | ■ Swimming Lessons |

Note: This list is not meant to be all-inclusive.

Please Note: The IRS does not allow Over-the-Counter (OTC) medicines or drugs to be purchased with Health Care FSA funds unless accompanied by a prescription and the prescription is filled by a pharmacist. If you have an OTC prescription, you can use your benefits card for these purchases.

Ineligible Over-the-Counter Medicines and Drugs (unless prescribed in accordance with state laws)

- | | | |
|---------------------------------|--|---|
| ■ Acid controllers | ■ Cough, cold & flu | ■ Medicated nasal sprays, drops, & inhalers |
| ■ Acne medications | ■ Denture pain relief | ■ Medicated respiratory treatments & vapor products |
| ■ Allergy & sinus | ■ Digestive aids | ■ Motion sickness |
| ■ Antibiotic products | ■ Ear care | ■ Oral remedies or treatments |
| ■ Antifungal (Foot) | ■ Eye care | ■ Pain relief (includes aspirin) |
| ■ Antiparasitic treatments | ■ Feminine antifungal & anti-itch | ■ Skin treatments |
| ■ Antiseptics & wound cleansers | ■ Fiber laxatives (bulk forming) | ■ Sleep aids & sedatives |
| ■ Anti-diarrheals | ■ First aid burn remedies | ■ Smoking deterrents |
| ■ Anti-gas | ■ Foot care treatment | ■ Stomach remedies |
| ■ Anti-itch & insect bite | ■ Hemorrhoidal preps | ■ Unmedicated nasal sprays, drops & inhalers |
| ■ Baby rash ointments & creams | ■ Homeopathic remedies | ■ Unmedicated vapor products |
| ■ Baby teething pain | ■ Incontinence protection & treatment products | |
| ■ Cold sore remedies | ■ Laxatives (non-fiber) | |

OTC items that are not medicines or drugs remain eligible for purchase with FSAs. You can use your benefits card for these items.

Eligible Over-the-Counter Items (Product categories are listed in bold face; common examples are listed in regular face.)

- | | | |
|--|--|---|
| ■ Baby Electrolytes and Dehydration
Pedialyte, Enfalyte | ■ Elastics/Athletic Treatments
ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts | ■ Hearing Aid/Medical Batteries |
| ■ Contraceptives
Unmedicated condoms | ■ Eye Care
Contact lens care | ■ Home Health Care (limited segments)
Ostomy, walking aids, decubitis/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedicated wound care, wheel chairs |
| ■ Denture Adhesives, Repair, and Cleansers
PoliGrip, Benzodent, Plate Weld, Efferdent | ■ Family Planning
Pregnancy and ovulation kits | ■ Incontinence Products
Attends, Depend, GoodNites for juvenile incontinence, Prevail |
| ■ Diabetes Testing and Aids
Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products | ■ First Aid Dressings and Supplies
Band Aid, 3M Nexcare, non-sport tapes | ■ Prenatal Vitamins
Stuart Prenatal, Nature's Bounty Prenatal Vitamins |
| ■ Diagnostic Products
Thermometers, blood pressure monitors, cholesterol testing | ■ Foot Care Treatment
Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles | ■ Reading Glasses and Maintenance Accessories |
| ■ Ear Care
Unmedicated ear drops, syringes, ear wax removal | ■ Glucosamine &/or Chondroitin
Osteo-Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements | |

For additional information, please contact Benefit Advantage at 800-686-6829.



Benefit Advantage

EMPLOYEE TAX SAVINGS WORKSHEET

Estimate your tax bracket and/or check with your tax advisor for an accurate estimate.

ESTIMATED TAX BRACKET

15%

25%

28%

33%

35%

DO THE MATH:	Column A	Estimated Out Of Pocket	Column B
Federal Tax Bracket:	%	Medical Expenses:	
FICA:	7.65 %	Dependent Care Expenses:	
		Total Expenses:	
State Tax – if applicable:	%		
Total Tax Percentage (Sum)	%		

Calculate Your Personal Tax Savings

Enter Column **B** Total:

Multiply by Column **A** % Total:

X _____

**ESTIMATED ANNUAL TAX SAVINGS
USING THE CAFETERIA PLAN:**



Benefit Advantage

EMPLOYEE WORKSHEET

Category 1: Unreimbursed Medical Expenses (annual)

Consult your employer or Benefit Advantage for the max you may elect.

\$ _____ Acupuncture
_____ Ambulance Hire
_____ Artificial Limbs or Teeth/Dentures
_____ Birth Control Pills
_____ Birth Prevention Surgery/Sterilization
_____ Braces
_____ Braille-Books & Magazines
_____ Care for Handicapped/Mentally Disabled Dependent
_____ Childbirth Classes
_____ Chiropractors
_____ Coinsurance/Co pays
_____ Communication Equipment – Deaf
_____ Contact Lenses and Supplies
_____ Corrective Eye Surgeries (RK, etc.)
_____ Crutches
_____ Deductible
_____ Dental Fees/Treatment
_____ Dermatologist
_____ Diagnostic Fees
_____ Eyeglasses, including Exam Fee
_____ Guide Dog/and it's upkeep
_____ Hearing Devices & Batteries
_____ Hospital Bills
_____ Infertility Treatments
_____ Insulin/Diabetic Supplies
_____ Laboratory Fees
_____ Lodging for Medical Care (limit/night)
_____ Mileage for Medical Care (limit/mile)
_____ Obstetrical Expenses
_____ Orthodontia
_____ Orthopedic shoes
_____ Osteopaths
_____ Over the counter medicines (OTC)
_____ Oxygen
_____ Physical Therapy
_____ Physician/Surgical Fees
_____ Podiatrist Fees
_____ Practical Nurse
_____ Prescription Medicine
_____ Psychiatric/Psychologist Fees
_____ Routine Physicals
_____ Smoking Cessation (Prescription Only)
_____ Smoking Programs
_____ Therapeutic Care for Drug/Alcohol Addiction
_____ Vaccines
_____ Wheelchair
_____ X-rays

\$ _____ Total

Remember you can see IRS publication 502 or contact Benefit Advantage for a more comprehensive list of eligible expenses.

Category 2: Daycare Expenses (annual)

\$ _____ per week x 52 weeks = _____

Transfer Category 1 and Category 2 to the appropriate areas on your enrollment form.

Your annual elections will be divided by the number of pay periods during the plan year to give you the amount to be deducted each pay period.

Can I change my election during the plan year?

You may be able to change your Medical FSA election during the plan year if you experience a “Change in Status” event and if the change is consistent with the event, such as:

- A change in your legal marital status.
- A change in the number of tax dependents
- Termination or commencement of employment by the employee, spouse or dependent.
- A change in employment status that results in gaining or losing eligibility for health coverage.
- Medicare or Medicaid entitlement for the employee, spouse or dependent.
- A change in cost or coverage (for Dependent Care account only).



Still
have
Questions?

Benefit Advantage can answer your questions about your personal situation and give you a better idea of how an FSA can benefit you.

Just call (800) 686-6829 and press 4 for the Flex Dept.

Also, you can log onto our website

www.benefitadvantage.com for more information.



Benefit Advantage

FREQUENTLY ASKED QUESTIONS

Q1 What are the advantages to a Health Flexible Spending, or LTD Health Flexible Spending Benefit Plans, and how will it affect me?

A1 The Health Flexible Spending, and LTD Health Flexible Spending Benefit Plans are another benefit we are pleased to offer our employees. These plans allow you to have certain expenses deducted from your paycheck before taxes, thus reducing the amount of taxes you pay, giving you more spendable income for the year. You have three choices. They are:

1. Pre-tax treatment of insurance premiums (Employer Sponsored Group Plans only)
2. Health Care Reimbursement Account (i.e.: medical, dental and vision expenses.)
3. Dependent Care Reimbursement Account (i.e.: daycare, babysitter)

Babysitter must report income.

Q2 Do I have to participate in all choices?

A2 No. Those who do not have children, a spouse or parents requiring daycare will not be interested in the Dependent Care Account. Most will probably want to participate in the Pre-tax premium coverage and the Health Care Reimbursement Account. Employees can enroll in any combination of the choices or in none at all. The decision is yours.

Q3 Is this an automatic election or do I need to sign a form?

A3 Every employee must complete a form(s) to enroll or to decline participation. Return your completed form(s) to the Human Resource Department on or before the last day of enrollment.

Q4 Can I change my election amount or get into the plan after the beginning of the plan year?

A4 You can change your election during the plan year, only if you have a change in family status, such as marriage, divorce, death, birth, or adoption. Otherwise, you will have to wait until the next enrollment period. The change you make must be consistent with the qualifying event. If you have any of the above qualifying events, you must contact your Human Resource Department within 30 days of the event.

Q5 Who determines what an eligible expense is that I can deduct on a pre-tax basis?

A5 The IRS formulates the guidelines for the Reimbursement Accounts and determines what is eligible.

Q6 How do I get reimbursed for Health Care expenses?

A6 To obtain reimbursement from Benefit Advantage you must send a copy of your Explanation of Benefit Form (EOB) from your insurance company or itemized receipt and complete a Health Care Reimbursement Request Form.

For your convenience, additional Reimbursement Request Forms are available in your Human Resource Department or on Benefit Advantage's website at: www.benefitadvantage.com. If the expense is for a service that is not eligible for reimbursement under your Insurance plan (i.e.: eyeglasses), send a copy of the itemized statement for the services that were provided. Please note that we cannot accept credit card receipts or canceled checks as proof of service.

If you know your monthly health care expenses will remain at the same dollar amount for the calendar year, (i.e. orthodontics) you are encouraged to use a Recurring Health Care Reimbursement Request Form. This allows you to submit the reimbursement form only once to Benefit Advantage and we will see that you are reimbursed accordingly. **You must notify us if the provider or amount of your claim changes.** This form is also available in your Human Resource Department or on Benefit Advantage's website at: www.benefitadvantage.com. **The Recurring Claim Form does not carry over into the next plan year.** At re-enrollment time, you must fill out a new Recurring Form and submit it to Benefit Advantage.

Q7 I've been deducting medical and dental expenses on my income taxes. Can this continue if I enroll in the Health Care Flexible Spending Benefit Plan?

A7 You may not claim expenses reimbursed from your Health Care Flexible Spending or LTD Health Care Flexible Spending Plans on your tax return.

Q8 If I allocate \$100 into my Health Care Expense Account or LTD Health Care Expense Account, and I incur only \$80 of charges for the calendar year, what happens to the \$20?

A8 The IRS states that if you do not have expenses that equal the money you have set aside on a pre-tax basis, you will be allowed to carryover up to \$500 to the subsequent plan year. Any money over the \$500 carryover limit will be forfeited. This is why we ask you to be cautious with your election. Your employer cannot return forfeited amounts directly to you.



Benefit Advantage

FREQUENTLY ASKED QUESTIONS

Q9 What forms do I need to send to Benefit Advantage for reimbursement for dependent care expenses?

A9 You need to complete a day care Reimbursement Request Form or send the Reimbursement Request Form with receipts showing amount of payment, date of service provided, Tax I.D. or Social Security number of your dependent care provider. If your dependent care provider does not issue receipts, a signature line is provided on the reimbursement form for their signature and Tax I.D. or Social Security number.

If you know your monthly dependent care expense will remain at the same dollar amount for the calendar year, you are encouraged to use the Recurring Dependent Care Reimbursement Request Form. This form allows you to submit the reimbursement form only once to Benefit Advantage and we will see that you are reimbursed accordingly. **You must notify us if the provider or amount of your claim changes.** Additional forms are available in your Human Resource Department. **The Recurring Claim Form does not carry over into the next plan year.** At re-enrollment time, you must fill out a new Recurring Form and submit it to Benefit Advantage. Recurring claims are released at the end of the first full week of each month.

Q10 My mother-in-law baby-sits for my two children. She doesn't claim this income on her income taxes. Can I participate in the dependent care account?

A10 No. You may participate in the Dependent Care Reimbursement Account only if the daycare provider claims the amount you pay them on their income taxes.

Q11 I over-calculated my dependent care expenses. Can I get the leftover money in my account at the end of the year?

A11 No. Money left in your dependent care account will be forfeited.

Q12 I am currently using the Child Care Credit on my income tax return. Can I use the Dependent Care Spending Benefit Plan also? Which gives me greater savings?

A12 The Dependent Care Account allows immediate elimination of Federal, State (except PA and NJ) and FICA taxes on expenses up to \$5,000 regardless of the number of children.

It is possible to use both; however, expenses in the Dependent Care Account reduce expenses allowed by the Child Care Credit dollar for dollar.

Please contact the individual who prepares your income tax return for assistance in determining which program provides the greatest savings for you.

Q13 How does participation in the Health Flexible Spending Benefit Plan affect information on my W-2 form?

A13 Your taxable income on the W-2 form will be reduced by contributions to any portion of the Flexible Benefit Plan. Funds contributed to the Dependent Care Account will be shown in a separate location on the W-2 form as a non-taxable item.

Q14 If I terminate employment, what happens to the money I have allocated to the Plan?

A14 You will have a run-out period following termination to submit claims for reimbursement of expenses that were **incurred before or on your termination date.** Any unused amount after the run-out period will be forfeited if you terminate with a positive balance. You may be eligible to elect to continue your participation in the Health Care Reimbursement Account with COBRA.

Q15 Once I file an eligible medical, dental, or dependent care expense, how long do I have to wait until Benefit Advantage reimburses me?

A15 Benefit Advantage sends out reimbursements on a daily basis. Benefit Advantage guarantees a 5 day turnaround on claims. You can review your claim status at www.benefitadvantage.com.

Q16 Will I receive a report showing me how much money I have used from the Plan?

A16 You may view your account status at anytime at www.benefitadvantage.com. On Benefit Advantage's website you can review your claim history, payment history and current balance.

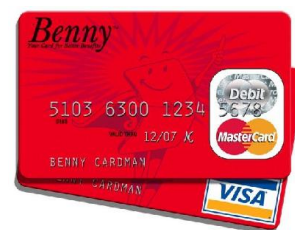
Q17 Who do I contact with questions or concerns on the Health Flexible Spending Account Benefit Plan?

A17 Call Benefit Advantage at (920) 339-0351 or (800) 686-6829.



Benefit Advantage

FREQUENTLY ASKED QUESTIONS



1. What is a Prepaid Benefits Card?

A Prepaid Benefits Card is a special-purpose MasterCard® Card or Visa® Card that gives participants an easy, automatic way to pay for qualified health care/benefit expenses. The Card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), Health Savings Accounts (HSAs), and Qualified Transportation Accounts (QTAs).

2. How does the Prepaid Benefits Card work?

It works like a MasterCard® Card or Visa® Card, with the value of the participant's account(s) contribution stored on it. When participants have qualified eligible expenses at a business that accepts MasterCard debit cards or Visa debit cards, they simply use their Card. The amount of the qualified purchases will be deducted – automatically – from their account and the pre-tax dollars will be electronically transferred to the provider/merchant for immediate payment.

3. How does the Prepaid Benefits Card change how I am reimbursed for expenses?

Before the Prepaid Benefits Card became available, participants were required to first make a contribution from their paychecks into their FSAs. Participants then had to pay for their eligible expenses at the time of purchase, submit claim forms along with all receipts, and then wait for the reimbursement to be processed. Checks were issued and mailed to the participants, who then cashed the checks. In essence, participants “paid twice” – through payroll deduction and then at the point of sale – then they had to wait for reimbursement.

However, with the Prepaid Benefits Card, participants simply swipe their Cards and the funds are automatically deducted from their respective employee benefit account(s) for payment. The Card eliminates **most** out-of-pocket cash outlays and paperwork, as well as the need to wait for reimbursement checks.

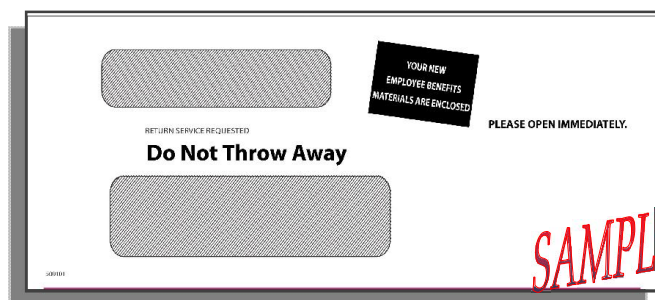
4. Is the Prepaid Benefits Card just like other MasterCard Cards or Visa® Cards?

No. The Prepaid Benefits Card is a special-purpose MasterCard® Card or Visa® Card that can be used **only** for qualified health care/benefits expenses. It cannot be used, for instance, at gas stations or restaurants. There are no monthly bills and no interest.

5. How many Prepaid Benefits Cards will I receive?

You will receive two Cards (unless the participant has only a Qualified Transportation Account, in which case one Card will be issued). If you would like additional Cards for other family members, please contact Benefit Advantage at (800) 686-6829.

★ Please watch for your cards in the mail (DO NOT THROW AWAY). See sample envelope to the right...



**SAMPLE
ENVELOPE**

6. Do I need a new Prepaid Benefits Card each year?

As long as the respective employee benefit account(s) remain part of the participant's benefit plan and you elect to participate each year, the Prepaid Benefits Card will be loaded with the new annual election amount at the start of each plan year or incrementally with each pay period, based on the type of account(s) you have.

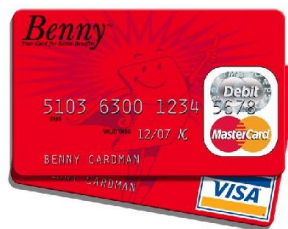
7. What if the Prepaid Benefits Card is lost or stolen?

Participants should call their Plan Administrator to report a Card lost or stolen as soon as they realize it is missing, so the Administrator can turn off their current Card(s) and issue replacement Card(s). Replacement Cards are \$5.00 each, which will be deducted directly from the participant's pre-tax account.



Benefit Advantage

FREQUENTLY ASKED QUESTIONS



**ACTIVATE
YOUR
CARD**

1. How do I activate the Card?

Participants should call the toll free number on the activation sticker on the front of the Card or call Benefit Advantage at 800-686-6829 for assistance.

Participants can use both Cards once the first Card is activated – they do not need to activate both.

They should wait 1 business day after activation to use their Cards. Each Card user should sign the Card with his or her own name.

2. What dollar amount is on the Prepaid Benefits Card when it is activated?

For Health Care FSAs, the dollar value on the Card will be the annual amount that participants elected to contribute to their respective employee benefit account(s) during their annual benefits enrollment. It's from that total dollar amount that eligible expenses will be deducted as participants use their Cards or submit manual claims. Some other types of accounts, like Dependent Care FSAs, HRAs, and transportation accounts, are funded incrementally at each pay period, so it is especially important to be aware of account balances in order to avoid Card declines at the point of service.

IT'S IMPORTANT TO SAVE YOUR RECEIPTS!

Your Prepaid Benefits Card will definitely improve your cash flow. However, be aware that the IRS requires the Card be used only for eligible expenses. Most of the time, we can verify the eligibility of the expense automatically. There are instances when you'll receive a letter/notification asking you to furnish an itemized receipt to verify the expense. When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your Card suspended until receipts have been submitted and approved.

What is an itemized receipt?

An itemized receipt must include: merchant or provider name, services received or item purchased, date of service, and amount of the expense.

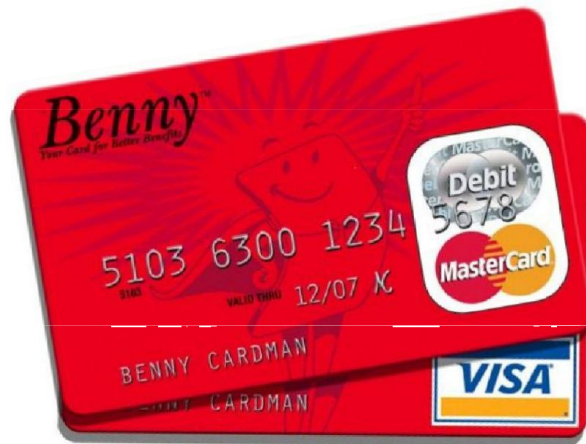
★Cancelled checks, handwritten receipts, card transaction receipts or previous balance receipts cannot be used to verify an expense.

We suggest that you keep itemized receipts in one place so they're readily available when you receive a request.



GUIDELINES FOR USING THE BENNY CARD

The IRS has certain restrictions for the use of the Benny™ Card with an FSA or HRA plan. Typically 80%-90% of Benny™ Card transactions will auto-approve at the Point-Of-Sale (POS). The lesser % must be documented via claim submission to Benefit Advantage. Please carefully review the substantiation requirements outlined below:



POINT-OF-SALE APPROVAL

Most retail drug and grocery stores have an inventory approval system (IIAS) that recognizes qualified healthcare items at the cash register. RX's, medical supplies, etc. purchased at stores such as Walgreens, Wal-Mart, and CVS (to name a few) should auto-approve and should not typically require documentation of the transaction.

CO-PAY MATCH

The Benny™ Card recognizes your employer's insurance plan co-pays for physician office visits, RX's and ER/Urgent Care visits. These transactions should auto-approve and should not require documentation of the transactions.

RECURRING EXPENSE

The second time that a Benny™ Card transaction has been substantiated for the same amount in the same setting it will be automatically approved from then on for that plan year.

CLAIM SUBMISSION

IRS guidelines require that all other Benny™ Card transactions be substantiated by submitting a claim, again this should be a small % of the Benny™ Card transactions. Participants will be notified if they must submit proof of the transaction.

KEY POINTS TO REMEMBER:

Documentation must include:

- Type of service
- Date of service

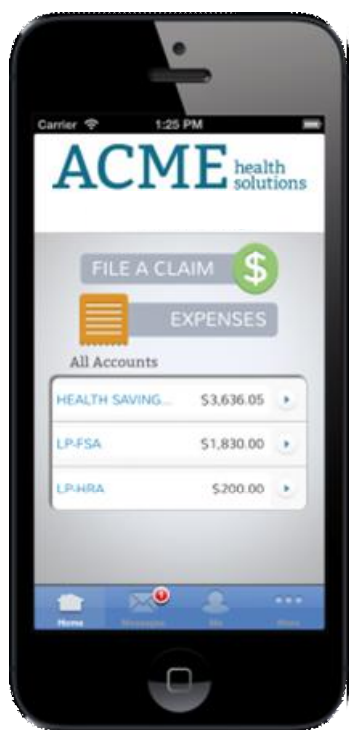
The Benny™ Card should only be used for expenses that are incurred in the current plan year and while you are a participant in the Plan. The Benny™ Card should not be used to pay for a prior plan year expense.

One of Benefit Advantage's goals is to provide best in class customer service! So, if you should have any questions or concerns, please contact us at: (800) 686-6829.



Mobile Application

With the convenience of a mobile device, you can see your available balance anywhere, anytime as well as file claims and upload receipts!



For complete on-the-go access to your FSA and DCAP benefits, download our mobile app. Benefit Advantage is pleased to announce your employees now have access to our mobile app for complete account access from their mobile device.

The Benefit Advantage App is available on both the iPhone and Android platforms.

- **Use your camera to submit claims**
- **Verify outstanding Benny Card charges**
- **View account balances**
- **View claim denials**
- **Receive alerts**
- **View pending submissions**

The Benefit Advantage App is a convenient way to manage your FSA and DCAP plans on the go and at the time of service!

You can download the Benefit Advantage App from the [iTunes App Store](#) or from [Google Play](#). You can find the mobile app by searching benefitadvantage.com.



Benefit Advantage

PO Box 5546 De Pere, WI 54115-5546
Phone (800) 686-6829
Fax (920) 339-0038
E-mail: claims@benadvan.com

Company Name: _____

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Print Your Name: _____

Print Your SS#: _____

Effective Date: _____

The information listed below is necessary to completely process the direct deposit funds into a specific bank account. (Please print all of the following information.)

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of \$10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the \$10.00 fee.

☐ New

☐ Change

☐ Cancel

☐ Checking (Must attach voided check)

☐ Savings (Please verify information with bank)

This information is for Benefit Advantage's use only and will not be disclosed to an outside party.

Transit ABA Routing #: _____

Account Number #: _____

Name of Bank: _____

I authorize my Section 125 Health Care FSA, Dependent Care FSA, Transit & Parking FSA, and/or Section 105 HRA reimbursements to be sent to the financial institution listed above and to be deposited in the designated account. I understand I may direct deposit to only one bank account.

In the event funds are deposited erroneously into my account, I authorize Benefit Advantage to debit my account not to exceed the original amount of the credit.

I also understand that all direct deposits are made through the Automated Clearing House (ACH), and that funds availability is subject to the limitations of the ACH as well as my financial institution. Benefit Advantage will not be held liable for any bank fees, overdrafts, etc... associated with these reimbursements.

Employee Signature: _____ **Date:** ____/____/____

Return this form to address or fax number at the top of the page.

You may review your account at www.benefitadvantage.com for balance details



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Fax (920) 339-0038
E-mail: claims@benadvan.com

Company Name:_____

Health Care FSA CLAIM FORM

☐ **Please check if this is a new address**

There is a \$25 minimum payment amount.

You must attach documentation that includes the following information for your claim to be paid:

- Date(s) of Service Performed
- Description of Service Performed *(i.e. eye exam, co-pay)
- Amount of expense incurred
- Name of Patient, & Service Provider

*Undefined codes are not acceptable descriptions of your expense.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal Revenue Service regulates this Flexible Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses qualify for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** ____/____/____

Original receipts will not be returned, please keep a copy for your own records.

You may review your account at www.benefitadvantage.com for balance details.



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HOW TO FILE YOUR REQUEST

DEFINITION OF MEDICAL CARE:

Must be “for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body”. Special rules may apply.

STEP I

Complete ALL personal information on the reimbursement request form. All items you are requesting reimbursement for should be itemized. Failure to complete your claim form could result in a delay or denial of your claim.

STEP II

HEALTH CARE FLEXIBLE SPENDING ACCOUNT:

Cancelled checks, balance due statements, cash register receipts or credit card statements **are not acceptable per IRS Regulations**. The only exception is that cash register receipts are allowed for contact lens supplies, eligible over the counter expenses and diabetic supplies. Photocopies and faxes of documents are acceptable. We will not return original receipts.

Attach proper documentation to the claim form:

- The insurance explanation of benefits (EOB) indicating the amount for which you are responsible (including deductibles). Any medical, dental, or vision expense covered by insurance (in part or in full) must first be submitted to your insurance carrier.

OR

- An itemized bill with the following (if you have no insurance coverage for your health care expense).
 - Name of provider and patient
 - Service cost, date, and description
 - Notation when there is NO insurance coverage

OR

- Co-pay receipts if you are covered under an HMO or a prescription drug plan.

If you have more claims than the spaces provided please attach additional claim forms.

STEP III

SIGN the request form.

The Internal Revenue Service regulates this Flexible Spending Account. Our documentation guidelines are intended as a means to qualify your expenses for approval and reimbursement. It is the responsibility of each participant to comply with these guidelines and to avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements will delay the payment of your claim.

Our goal is to process payments within 24 hours of receipt with proper documentation. We guarantee a 5 working day turnaround maximum. There is a \$20 stop payment fee for all checks that need to be reissued. Direct Deposit is available at no charge and is highly recommended.

This outline is intended for quick reference. If you have any additional questions, please call the Flexible Spending Account Department at (920) 339-0351 or (800) 686-6829, available 8-4:30pm, Monday through Thursday and 8-4 pm on Friday Central Standard Time.



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Fax (920) 339-0038

E-mail: claims@benadvan.com

Company Name: _____

Dependent Care CLAIM FORM

NAME:	Last	MI	First	SS#:		
ADDRESS:	Street	City	State	ZIP	PHONE :	()

☐ Please check if this is a new address

DAYCARE CLAIM FORM						
DATE OF SERVICE FROM TO		DEPENDENT NAME	DEPENDENT BIRTH DATE	CLAIM AMOUNT	PROVIDER TAX ID#/SS#	*PROVIDER NAME
				\$		
				\$		
				\$		
Total:				\$		

Dependent Care expenses are reimbursed up to the cash balance in your account. Unpaid claims are reimbursed as more funds are received from your employer and credited to your account.

There is a \$25 minimum payment amount.

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of \$10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the \$10.00 fee.

PROVIDER VERIFICATION

Signature of the Provider is mandatory if no Federal Tax ID is given above or documentation attached and the daycare provider must declare this as income on their tax return.

I verify that the above charges are accurate as described.

Provider Signature

Federal Tax ID Number

Date

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal Revenue Service regulates this Dependent Care Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses qualify for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: ____/____/____

You may review your account at www.benefitadvantage.com for balance details.



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HOW TO FILE YOUR REQUEST

DEFINITION OF DEPENDENT CARE:

Must be “for care of an eligible dependent by IRS regulations enabling you or your spouse to work or to seek employment”

DEFINITION OF ELIGIBLE DEPENDENTS:

The IRS states an eligible dependent is less than 13 years old and living with you. An eligible dependent may also include your mentally or physically impaired spouse/dependent/child that is living with you and incapable of caring for him or her self.

The provider of the care **MUST** declare the funds you pay them as income

CHECKLIST

- ✓ Fill out only if you are manually submitting claims throughout the year
- ✓ Documentation must be attached
- ✓ Sign the bottom of the claim form

The provider **MUST** sign the claim form or include a tax id in order to process the claim.



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RECURRING DAYCARE REIMBURSEMENT REQUEST FORM

A Recurring Claim allows Benefit Advantage to automatically enter and post a claim to your Dependent Care Account at the end of the first full week of every month. Reimbursements **to you** will occur as funds are received by Benefit Advantage from your employer. Deposit dates may vary month to month. Benefit Advantage will not be held responsible for any late charges or overdraft fees related to this payment.

Employer Name: _____

Employee Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Daytime Phone #: _____

I VERIFY THAT I MAKE REGULAR ONGOING PAYMENTS TO:

Name of Day Care Provider: _____ Provider Tax ID Number: _____

Name of Dependent: _____ Birth Date: ____/____/____

The charge for the care is \$_____ per month, beginning on ____/____/____ & ending on ____/____/____.

Note: This recurring claim is only valid for the current plan year.

PROVIDER VERIFICATION

Signature of the Provider is mandatory if no Federal Tax ID or documentation is given. Also, the daycare provider must declare this as income on their tax return.

I verify that the above charges are accurate as described.

Provider Signature **Federal Tax ID Number** **Date** ____/____/____

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

I agree that if the amount changes or if for any reason, such as illness or vacation, the expenses are not incurred as scheduled, I will **immediately** notify Benefit Advantage in writing.

The Internal Revenue Service regulates this Dependent Care Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses qualify for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** ____/____/____

You may review your account at www.benefitadvantage.com for balance details.



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HOW TO FILE YOUR REQUEST

DEFINITION OF DEPENDENT CARE:

Must be “for care of an eligible dependent by IRS regulations enabling you or your spouse to work or to seek employment”

DEFINITION OF ELIGIBLE DEPENDENTS:

The IRS states an eligible dependent is less than 13 years old and living with you. An eligible dependent may also include your mentally or physically impaired spouse/dependent/child that is living with you and incapable of caring for him or her self.

The provider of the care **MUST** declare the funds you pay them as income

CHECKLIST

- √ Fill out only if you are **not** manually submitting claims throughout the year
- √ Documentation must be attached
- √ Sign the bottom of the claim form

The provider **MUST** sign the claim form or include a tax id in order to process the claim.



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RECURRING ORTHO CARE REIMBURSEMENT REQUEST FORM

Employer Name: _____

Employee Name: _____

Address: _____

Social Security #: _____

Daytime Phone #: _____

ORTHO CONTRACT MUST BE ATTACHED

☐ I have attached a signed statement from the above stated Provider verifying the amount and frequency of charges. I agree that if the amount changes or if for any reason the expenses are not incurred as scheduled, I will notify Benefit Advantage immediately in writing.

Name of Provider: _____

Name of Patient: _____

Ortho charge: \$_____ per month, beginning on: ____/____/____ & ends on : ____/____/____

Start Date of Treatment: ____/____/____ Term of Treatment: ____/____/____

This claim form is only valid for the current plan year and will be posted to your Flexible Spending Account at the end of the first full week of every month.

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of \$10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the \$10.00 fee.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal Revenue Service regulates this FSA Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses qualify for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Signature: _____
Plan Participant Name

Date: ____/____/____

You may review your account at www.benefitadvantage.com for balance details.

CONSUMER PORTAL QUICKSTART GUIDE

Welcome to your Benefit Advantage Consumer Portal. This one-stop portal gives you 24/7 access to view your benefit information and manage your account(s). It enables you to:

Our one-stop portal provides you with:

- Anytime, anyplace access to your account(s), including 24/7/365
- Paperless administration, including online account summary reports
- Upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity details

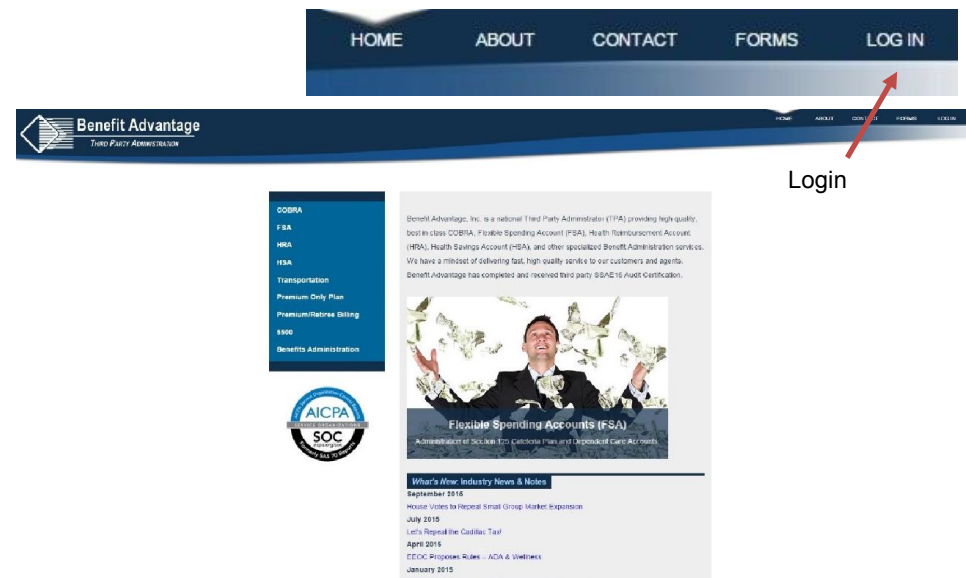
We know from Web usage statistics that you'll most likely use the portal to:

- File claims
- View account balances
- View account activity, including contributions, deductions, and payments
- View plan information, forms and notifications

The portal is designed to be easy to use and convenient.

You have your choice of two ways to navigate this site:

1. Work from sections within the Home Page, or
 2. Hover over the six tabs at top of Home Page to see drop-down menus.
- Just go to our Login Page at www.benefitadvantage.com
 - Click "Account Access (Employee)" under the Destination dropdown menu
 - Click "Continue"
 - Login to your account
 - If you are a NEW user, use your SSN (no dashes) to login.
Use the last 4 digits of your SSN as your password.
You will be prompted to change both immediately.



HOW DO I FILE A CLAIM?

1. To request reimbursement(s) from your account(s), you may select the link in the “I want to...” section, [File a claim](#).
2. To create a transaction from your account(s), complete the fields as prompted through the online transaction wizard.

Did you know? For a convenient alternative, you can use your debit card to pay for your medical expenses directly from your account.



HOW DO I GET MY REIMBURSEMENT MONEY FASTER?

The fastest way to get your money is to use your debit card at the point of sale to pay for expenses. If you did not use your debit card the quickest way to receive payment is to sign up online for direct deposit to your personal checking account.

From the **Home Page**, under the **Tools&Support** tab, click **Change Payment Method** under the “How Do I” section.

1. Select **Reimburse Myself Using Direct Deposit** and click **Change Payment Method**. The **Add Bank Account: Direct Deposit Setup** page displays.
2. Enter your bank account information, and click **Submit**.
3. The **Payment Method Changed** confirmation displays.
4. **If there is a bank validation requirement**, you will be notified on the portal to look for a small transaction or “micro-deposit” in your designated bank account in the next couple of days to enter online, which will validate your account.

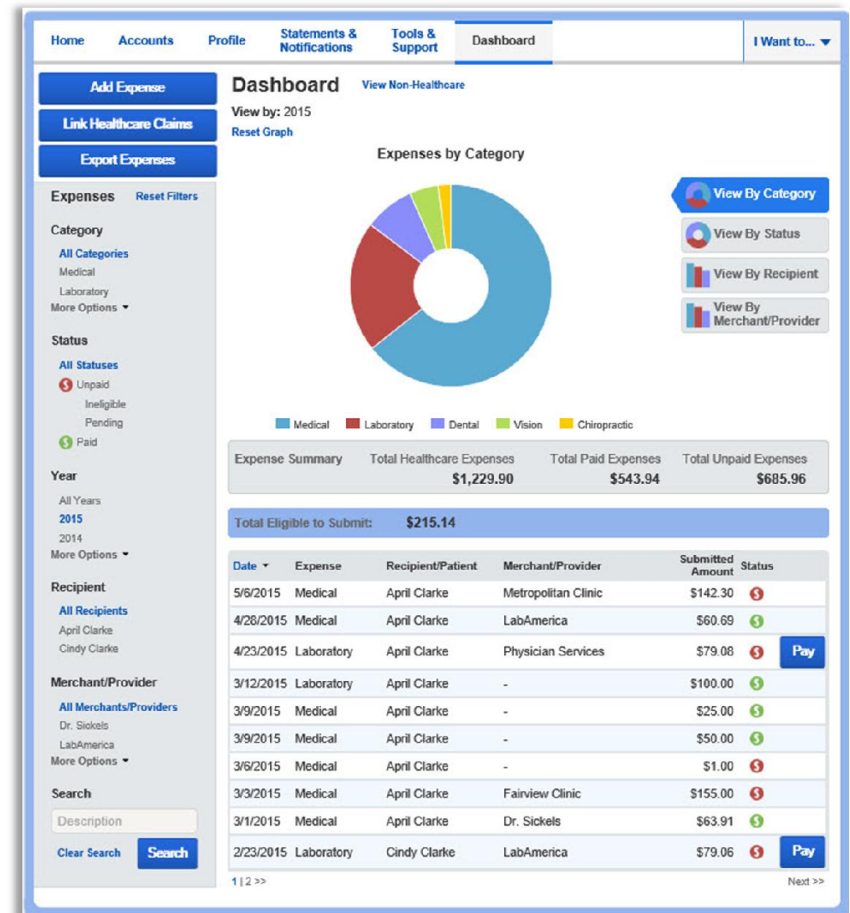
ALL HEALTH CARE EXPENSE ACTIVITY IN ONE PLACE

To view and manage ALL healthcare expense activity from EVERY source, use the **DASHBOARD**

1. On the **Home Page**, under the **Dashboard** tab. The 1View Dashboard provides you with an easy-to-use consolidated view of healthcare expenses for ongoing management of medical claims, premiums, and card transactions.
2. Easily filter expenses by clicking on the **filter options** on the left hand navigation pane or, by clicking on the **field headers** within the Dashboard.
3. You can search for specific expenses using the **search field** on the bottom left hand side of the screen.
4. Expenses can be exported into an Excel spreadsheet by clicking on the **Export Expenses** button on the upper left hand side of the page.

HOW DO I ADD AN EXPENSE TO THE DASHBOARD?

1. From the **Dashboard** click on the **Add Expense** button in the upper left hand side of the page.
2. Complete the expense detail fields. You can even upload a copy of the receipt and, add notes for your records.
3. Once the expense has been added to the **dashboard** you can pay the expense, if desired.



HOW DO I PAY AN EXPENSE?

1. You may process payments/ reimbursements for unpaid expenses directly from the **Dashboard** page.
2. Expenses will be categorized and **payment** can be initiated for unpaid expenses by clicking on the button to the right of the expense details.
3. You can filter the **Dashboard** to only view unpaid expenses by clicking on the **unpaid** status from the navigation bar on the left hand side of the screen.
4. Simply choose which expenses you would like paid and you will be presented with the eligible accounts to select where the claim should be paid.
5. When you click **Pay** the claim details from the dashboard will be pre-populated within the claim form. Review & edit the claim details by completing any required fields that remain blank.
4. You will have the option to either request a reimbursement/distribution to yourself or, pay the provider.

All Expenses		Total Eligible to Submit: \$340.89				
Medical						
Dental						
More Options ▾						
Status	Date	Expense	Recipient/Patient	Merchant/Provider	Submitted Amount	Status
	05/01/2014	Dental	Cindy Clarke	Dental Services Inc.	\$59.20	<div>Ⓢ Pay</div>

HOW DO I EDIT AN EXISTING EXPENSE IN THE DASHBOARD?

1. You can edit expense details for all claim statuses directly from the **Dashboard** page.
2. Expand the expense details visible by clicking on the expense line item from the Dashboard.
3. You will be presented with options to add expense notes, update the expense details, mark the expense as paid/unpaid or, remove the expense from the Dashboard.

		Total Eligible to Submit: \$215.14			
Date	Expense	Recipient/Patient	Merchant/Provider	Submitted Amount	Status
5/20/2015	Medical	Cindy Clarke	Metropolitan DentalCare	\$100.00	Ⓢ
5/6/2015	Medical	April Clarke	Metropolitan Clinic	\$142.30	Ⓢ
4/28/2015	Medical	April Clarke	LabAmerica	\$60.69	Ⓢ
4/23/2015	Laboratory	April Clarke	Physician Services	\$79.08	Ⓢ Pay
Expense Details					
		Description: X-rays		Date(s) of Service: 4/23/2015	
		Source: Online		Expense Amount: \$79.08	
		Received Date: 5/12/2015		Payable Amount: \$79.08	
		Upload Receipt(s)		View Receipt(s)	
		Mark as Paid		Remove Expense	
				Add Expense Note	
				Update Expense	



HOW DO I VIEW MY PAYMENT HISTORY?

1. On the **Home Page**, under the **Accounts** tab, click **Payments** from the Left-hand menu.
2. You will see payments made to date, including debit card transactions.

Home	Dashboard	Accounts	Tools & Support	Statements & Notifications	Profile	I Want to... ▼
Account Summary						
Account Activity						
Claims						
Payments						
Payments	Reset Filters					
Method						
All Methods						
Direct Deposit						
Status						
All Statuses						
Paid						
Date						
All Dates						
2015						

Date ▼	Number	Method	Status	Amount
12/23/2015	E00173896	Direct Deposit	Paid	\$130.00
09/24/2015	E00163976	Direct Deposit	Paid	\$62.96
09/16/2015	E00162943	Direct Deposit	Paid	\$175.48

HOW DO I UPDATE MY PERSONAL PROFILE?

1. From the **Home Page**, under the **Profile**, you will find links to update profile information including profile summary details, dependents, and beneficiaries.
2. Click the appropriate link on the Profile screen for your updates: **Update Profile** or **Add/Update Dependent** or **Add Beneficiary**. Some
3. profile changes will require you to answer an additional security question.
4. Complete your changes in the form.
5. Click **Submit**.

Support	Notifications
---------	---------------

Profile	Banking	Login Information
---------	---------	-------------------

Profile / Update Profile

Your Profile Needs Attention
We do not have an email address on file for you. Please enter your email address to receive your communications about your account electronically.

Contact Information

Name *

Birth Date *

Address *

Home Phone * - -

Email Address*

Confirm Email Address

By providing an email address, you will receive communications electronically about your benefits in lieu of paper documents. Your email address will not be shared or used for any other purpose.

Demographic Information

Gender ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single