O.C.A. Benefit Services LLC

Your Prescription to a Healthier Bottom Line

3705 Quakerbridge Road, Suite 216, Mercerville, NJ 08619 **Office 609/514-0777** **Fax 609/514-2778**

Haddon Township Board of Education

ENROLLMENT FORM

TYPE OF ACTIVITY

☐ New Hire ☐ Open Enrollment ☐ Re-Hire ☐ COBRA Elect *(Debit Cards not available)* _____/_____/_____

(Required: date coverage begins)

EMPLOYEE INFORMATION

First Name	***Last Name***	***M.I.***	***Social Security #***

Mailing Address	***Apt/Suite #***	***City***	***State***	***Zip***

Date of Birth	***Gender***	***Daytime Phone #***	***Email Address***
_____/_____/_____	☐ Male ☐ Female	(_____)_____-_____	_____ ☐ .com ☐ .edu ☐ .net ☐ .org ☐ .us

ELECTED COVERAGE(S)

Electing FSA - indicate the PAY date in which the first deduction will be taken: _____/_____/_____

☐ FSA – Medical (Annual Contribution $_____) ☐ FSA - Dependent Care (Annual Contribution $_____)

☐ Participates with Company-sponsored medical plan (for purpose of assignment of co-pays with debit card use)

Employee Enrollment Authorization – REQUIRED FOR PROCESSING APPLICATION

I hereby certify that the information provided throughout to be correct and true to the best of my ability. Thereby ***(if applicable)*** authorize and direct my employer to reduce my salary on a per pay basis in the amount necessary to pay for the coverage(s) I elected from my paycheck. Such reductions, considered as elective contributions under the plan, will start with my first paycheck after the latter of the Plan Year effective date or the date my election form is processed by the Plan Service Provider. I further authorize future adjustments in the amount of my salary reduction if the carrier changes the cost of coverage in any program selected during the plan year. I also understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of the Internal Revenue Code. I understand that the selection of a benefit and the indication that a premium is to be paid does not necessarily include me in the insurance portions of this plan. In most instances an application for insurance must also be completed. By signing this form I am indicating which benefits I am electing. The selections will remain in effect until a subsequent election form is filed, in accordance with the plan. Lastly, I have read or been made aware that I may request from my Employer the Summary Plan Description (SPD) which contains the Plan information summary. This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in status or cost or coverage change as listed on the Status Change Matrix contained within the SPD.

_____ _____

Employee Signature **Date**

HR or Plan Administrator Signature – REQUIRED FOR PROCESSING APPLICATION

_____ _____

Employer Signature **Date**

Haddon Township Board of Education

*my*SourceCard™ Enrollment Agreement

As a participant in one or more of your Employer Plans you will receive a mySourceCard™ MasterCard® Debit Card issued by Benefit Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used ***exclusively*** for Qualified Expenses as defined by the plan(s) in which you participate. If the Card is issued pursuant to Employer Plans and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all invoices and receipts related to any expense paid with the Card; upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

For proper Cardholder Identification, please complete the following information.
Your Card will not be issued until this form is received by your Plan Service Provider.

Name on Card (Please Print):_____

21 characters maximum including spaces

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

Social Security Number:_____ Date of Birth:_____ Home Phone: (_____)_____

E-mail Address (**REQUIRED**):_____

Name on 2nd Card (Please Print):_____

21 characters maximum including spaces

Mother's Maiden Name (Security purposes only):_____

I acknowledge that I have read the above and know that there may be occasions when I will be required to submit the appropriate documentation to support my charges to keep the card active.

Employee Signature:_____ Date:_____

ALL FIELDS ARE REQUIRED FOR PROCESSING!

Haddon Township Board of Education

Employee Direct Deposit Authorization Form

Steps for Completing this Form:

1. Fill in ALL boxes below.
2. Attach voided check (**NOT Deposit Slip**) for a checking account or letter from bank for a saving account.
3. Sign and date form.
4. If the Employee is **NOT** the sole accountholder or has the authority of the accountholder to authorize O.C.A. Benefit Services to make direct deposits to the named account, then the accountholder would also need to sign below.

Last Name	***First Name***	***MI***

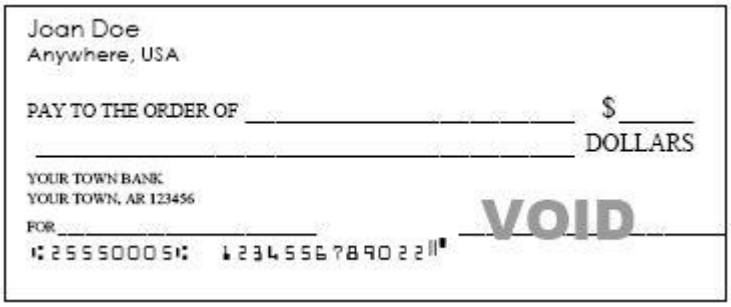
Social Security #	***Home Phone***	***Work Phone***

Direct Deposit Action:	***Effective Date***	***Account Type:***	***Account Ownership:***
☐ New ☐ Change ☐ Cancel	_____/_____/_____	☐ Checking ☐ Savings	☐ Self ☐ Joint ☐ Other

---------- ATTACH VOIDED CHECK HERE ----------

DO NOT attach a Deposit Slip as they do not provide the necessary information.

Individuals requesting funds be deposited to a Savings Account must submit a letter w/this form on bank's letterhead stating the account and routing #.



By signing this agreement, I authorize O.C.A. Benefit Services to initiate credit entries to the Account indicated above for the purpose of reimbursements and to initiate, if necessary, debit entries and adjustments for any credit entries made in error. (O.C.A. Benefit Services will NOT initiate debit entries or adjustments for credit without contacting the employee for approval first. The HR Department will be made aware of any approvals or declines of adjustments).

_____	_____
Employee Signature	**Date**
_____	_____
Signature of Second Account Holder	**Date**