O.C.A. Benefit Services
Your Prescription to a Healthier Bottom Line

Mid-Atlantic Home Health, LLC

Enrollment/Change of Status Form

Enrollment Activity

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

Mid-Year Change Activity

□ Adding Spouse/Dependent □ Removing Spouse/Dependent □ Change of Status/Election □ Termination

Reason for Change (i.e. Divorce, Marriage, Birth, etc.): _____

Effective Date

Effective Date (required for processing): ____/_____/_____
MM DD YEAR

Employee Information

Name (First/MI/Last):	Social Security #:
Mailing address:	

City:	State:	ZIP Code:

Gender: □ Male □ Female	Contact Phone #: (_____)_____-_____ □ Cell □ Home □ Work
Date of Birth: _____/_____/_____ MM DD YEAR	Email Address: _____ □ .com □ .edu □ .net □ .org □ .us

HRA Elected Coverage

HRA - Tier of Coverage: □ Employee Only □ Employee/Spouse □ Parent/Child □ Family □ **Add** □ **Change** □ **Term** □ **Waive**

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. 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. By signing this form I am indicating which benefits I am electing. 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 consistent with a change in status or Qualifying Life Event as listed on the Status Change Matrix contained within the SPD.

Employee Signature: _____ Date: _____

HR or Designated Signatory – REQUIRED FOR PROCESSING APPLICATION

Authorized Signature: _____ Date: _____

Dependent Information Form

Covered Dependent Information – REQUIRED FOR HRA ELECTIONS OTHER THAN SINGLE

Name (First/MI/Last):	Social Security #:	
Mailing address:		
City:	State:	ZIP Code:
Date of Birth: ____/____/______ MM DD YEAR	Gender: □ Male □ Female	Relationship: □ Child □ Spouse
Name (First/MI/Last):	Social Security #:	
Mailing address:		
City:	State:	ZIP Code:
Date of Birth: ____/____/______ MM DD YEAR	Gender: □ Male □ Female	Relationship: □ Child □ Spouse
Name (First/MI/Last):	Social Security #:	
Mailing address:		
City:	State:	ZIP Code:
Date of Birth: ____/____/______ MM DD YEAR	Gender: □ Male □ Female	Relationship: □ Child □ Spouse
Name (First/MI/Last):	Social Security #:	
Mailing address:		
City:	State:	ZIP Code:
Date of Birth: ____/____/______ MM DD YEAR	Gender: □ Male □ Female	Relationship: □ Child □ Spouse
Name (First/MI/Last):	Social Security #:	
Mailing address:		
City:	State:	ZIP Code:
Date of Birth: ____/____/______ MM DD YEAR	Gender: □ Male □ Female	Relationship: □ Child □ Spouse

(Company Name)

mySource Debit Card Request Form

Employee mySource Card Enrollment Agreement

Name (First/MI/Last):		Last 4 digits of SS #:
Mailing address:		
City:	State:	ZIP Code:
Mother's Maiden Name (for security purposes):	Contact Phone #: (_____)_____-_____ □ Cell □ Home □ Work	
Date of Birth: _____/_____/_____ MM DD YEAR	Email Address (REQUIRED): _____ □ .com □ .edu □ .net □ .org □ .us	

Employee mySource Card Request

Please note cardholder must be 18 years of age or older for additional card requests.
NOTE: There is a 21character maximum including spaces for the name on the card.

□ New Card □ Replacement Employee - Primary Cardholder (Please Print): _____

□ New Card □ Replacement Name on 2nd Card (Please Print): _____

□ New Card □ Replacement Name on 3rd Card (Please Print): _____

□ New Card □ Replacement Name on 4th Card (Please Print): _____

Employee Certification

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 per 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 itemized receipts related to any expense paid with the Card; upon request, you must submit these documents for review by OCA. 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.

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: _____

Employee Direct Deposit Authorization Agreement

Employee Direct Deposit Agreement

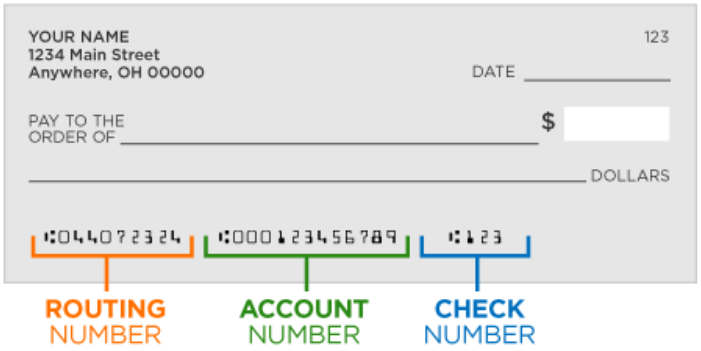
Name (First/MI/Last):	Last 4 digits of SS #:
Direct Deposit Action: □ New □ Change □ Cancel	Contact Phone #: (_____)_____-_____ □ Cell □ Home □ Work
Account Type: □ Checking □ Savings	Email Address: _____ □ .com □ .edu □ .net □ .org □ .us

Bank Information

Bank Name:	
Routing Number (9 digit #)	Account Number:

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

Please do not attached a deposit slip as they do not provide the necessary information. Individuals requesting funds be deposited to a Savings Account must submit a letter with this form on the bank's letterhead stating the account and routing #.



Employee Direct Deposit Authorization

By signing this agreement, I authorize OCA to initiate credit entries to the Account indicated above for the purpose to reimbursement and to initiate, if necessary, debit entries and adjustments for any credit entries made in error. (OCA 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: _____