LyfeSystems

Portable Account Enrollment Form

YOUR ENROLLMENT INFORMATION

Please provide the following information to activate your LyfeSystems account. **We strongly urge that you provide your email address and phone number** to allow us to communicate important account information which will be securely stored and accessible through our website at www.lyfesystems.com.

Name:		
Address:	**Address 2:**	
City:	**State:**	**Zip:**
Phone (Home):	**Phone (Cell):**	
Email:	**Employer Name:**	

Your first communication from LyfeSystems will arrive via email, or standard mail if you don't provide an email address. If it appears you have not received an email from LyfeSystems after signing up, please check your junk and/or spam folder(s), as the welcome email may have been diverted there.

HEALTH INSURANCE CURRENT STATUS

Are you covered under a spouse or significant other's policy? (Check One): Yes ☐ No ☐

Are you covered by military or government benefits? (Check One): Yes ☐ No ☐

Are you covered on a parent's policy? (Check One) Yes ☐ No ☐

ADDITIONAL EMPLOYERS

If you have more than one job, each employer could allow you to contribute to your LyfeSystems account. Please provide contact information for an individual at each employer (if any) so we may contact them on your behalf to explain the LyfeSystems system and why they should allow you to contribute to your LyfeSystems account. We will contact these individuals only during regular business hours.

Employer Name:		
Address:	**Address 2:**	
City:	**State:**	**Zip:**
Contact Name:	**Phone:**	

SPOUSE/DEPENDENT EMPLOYERS

Employers of your spouse and any dependents may also allow them to contribute to accounts the whole family can use. Please authorize us to contact these employers and provide the spouse/dependent name and the name(s) of their employer(s).

Spouse Name:		
Address:	**Address 2:**	
City:	**State:**	**Zip:**
Phone (Home):	**Phone (Cell):**	

Dependent Name:		
Address:	**Address 2:**	
City:	**State:**	**Zip:**
Phone (Home):	**Phone (Cell):**	

Dependent Name:		
Address:	**Address 2:**	
City:	**State:**	**Zip:**
Phone (Home):	**Phone (Cell):**	

USE OF FUNDS

I agree that the funds deposited in my Portable Healthcare Account are restricted for use only to pay for qualified healthcare expenses, as allowed by law and will remain accessible in my account until exhausted.

_____ (Initials)

FULL PREMIUM PAYMENT PROGRAM

If you choose, each month we pay your insurance policy premiums. **If you have sufficient funds, LyfeSystems will pay your premium.** If there is a shortage of funds, LyfeSystems will need to collect additional money from another source to pay your premium in full.

We collect your checking account information during sign-up so we will have access to an alternative source of funds whenever your LyfeSystems account has insufficient funds to pay the premium. And note that there are circumstances in which your LyfeSystems account may run short of funds, even if you are careful in monitoring your account balance. For example, when your policy renews each year, it is likely that the premium will also increase. In all cases where there is a LyfeSystems account funds shortfall, we withdraw only the balance of funds needed to pay the premium (we notify you via email of the date and amount of the withdrawal). Most premium drafts will occur between the 22nd and the 28th of the month (these dates can vary depending on weekends, holidays, and each insurance carrier's unique billing system).

Accurate and timely premium payment is essential, because insurance carriers will proceed with policy cancellation procedures if they do not receive full payment on or before the due date. Please manage your accounts to ensure you always have sufficient funds available to pay your monthly premium. You can view your account on-line at any time to check your balance through our website at www.lyfesystems.com. If you are having trouble logging in, please call our office to speak with one of our customer service representatives at 360-466-9100, or email us at support@lyfesystems.com.

If your bank account information is not on file or if one is not available and your funds are not sufficient to pay your premium, LyfeSystems will contact you once by email and once by phone to secure another source of funding. If we do not get a response within 2 business days, we notify you via email or letter that we attempted to reach you, and if we do not receive a response in the time required, your policy will be subject to the terms of cancellation for nonpayment as defined by your insurance company.

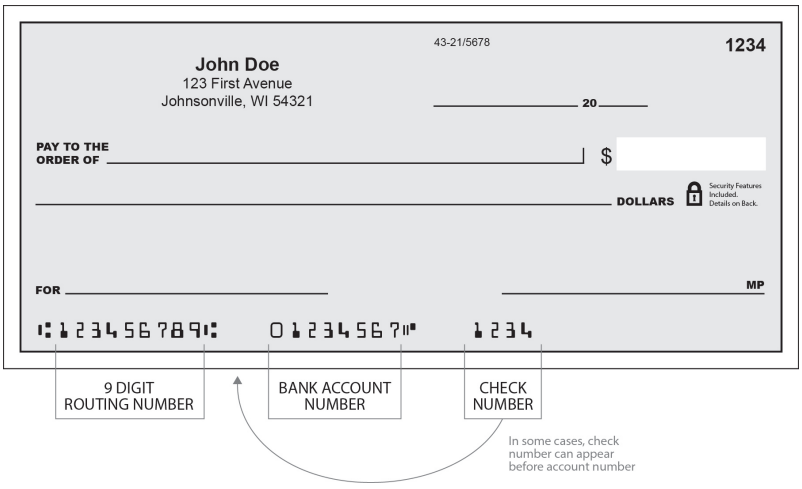
I have read and understand LyfeSystems' Full Premium Payment Program and agree that if I direct LyfeSystems to pay my insurance premium, the primary use of my LyfeSystems deposits will be to help ensure that my health insurance premium is paid in full each month.

_____ (Initials)

YOUR FINANCIAL INSTITUTION INFORMATION

PLEASE ATTACH A COPY OF A VOIDED CHECK WITH THIS APPLICATION.

Credit Union or Bank Account Information



Account Name/Title: _____

Name of Credit Union or Bank: _____

9 Digit ABA Routing Number: _____

Bank/Credit Union Account Number: _____

Account Type (checking or savings): _____

By signing the form you hereby permit LyfeBank to create and present an electronic check transaction to your financial institution in the amount LyfeBank requests to draw on the Routing/Account number provided. This amount will include the payment required to pay your insurance premium in full plus any owed LyfeBank service fees, if applicable.

This electronic check will be presented to your bank as needed to pay your insurance in full. Collections will take place approximately between the 22nd and the 28th of the month. This may vary based on holidays, weekends and each carriers' unique billing procedures. If this payment is rejected for any reason a Non-Sufficient Funds Fee of $29.00 will be applied.

I am electing to complete the banking account information on this form to participate in LyfeBank's Full Premium Payment Program.

_____ (Initials)

INSURANCE BILLING

As part of our service LyfeSystems will pay your premium for your available account funds. For us to pay your premium, we need to receive your bill. When signing up for insurance the LyfeSystems address will need to be entered in the billing address field (if available). On occasion, insurance companies misdirect the bills to the policyholder's address. Your insurance company will only issue one bill so if it arrives at your home LyfeSystems cannot pay your premium. If you receive a bill at your home, please scan and email your invoice or send a faxed copy to our office. Directions for emailing and faxing are available on our website at www.lyfesystems.com/employeeresources.

I have read and understand the Insurance Billing section.

_____ (Initials)

LYFESYSTEMS ACCOUNT HOLDER SERVICE CHARGES

A $10 per month service fee is charged (may be paid by employer during the term of your employment, but is to be paid by the account holder if not paid by the employer).

The services provided for by this fee may include, but are not limited to, the following:

A. Collect employee contributions from employer and deposit to employee LyfeSystems account.
B. On-line access to your current account balance, deposits, and expenditures.
C. Bill pay service for your health insurance policy or policies on file with LyfeSystems.
D. Pay invoices for medical services you submit to us or transfer to you from your LyfeSystems account funds needed to cover the cost of qualified medical expenses you paid out-of-pocket.

I have read and understand the LyfeSystems Account Holder Service Charges section.

_____ (Initials)

EXHAUSTED LYFESYSTEMS PORTABLE HEALTHCARE ACCOUNT

If your account balance is at zero, and you have made no deposits or there is no other account activity for 90 days, LyfeSystems will close your account. **LyfeSystems will notify you once by email and once by phone (at the number listed on your account profile) to report you have a premium to be paid when your account has reached a zero balance.** This notification will also confirm that LyfeSystems holds no responsibility for any prior payment arrangements that may have been made once the account has been closed.

If at a later date you wish to re-establish your LyfeSystems Membership, please contact our customer service department at 360-466-9100 to initiate steps to reactivate your account.

I have read and understand the Exhausted LyfeSystems Portable Healthcare Account section.

_____ (Initials)

TEXT OPT-IN

At LyfeSystems we strive to communicate with you efficiently and effectively to keep you informed of important LyfeSystems account details, including the balances available for use for qualified medical expenses. This includes regular messages to the email account you have provided to us and text messages to your mobile phone. We will send these messages no more frequently that twice a month. Please initial the authorization here to allow us to send account information text messages to the mobile phone number you choose. Thanks.

I authorize LyfeSystems to provide me with account-related information, including available balances, through regular text messages to the mobile phone number I have listed here: (Mobile phone number: _____).

_____ (Initials)

WHAT'S NEXT?

You will be able to purchase a growing list of other healthcare services, including subscription-based medical services and wellness programs from LyfeSystems. Make sure to return regularly to *www.lyfesystems.com* to check out the latest offerings.

THANK YOU!

Please sign and date below to confirm your agreement with all the terms of this application.

_____
Signature

_____
Date