Dear Flexible Spending Account (FSA) Enrollee:

Welcome to your FSA Plan! You now have 24x7 access to all your FSA needs on the web. To access your account simply log-on to www.fsa4me.com . Your user name is your first initial, last name (in all caps) and last four digits of your social security number (i.e. – John Doe 555-44-3333 would be JDOE3333). Your initial password is: **changeme**. Once on the website, you will be prompted to change your password and asked for a security challenge and response. From this point, it's easy to click your way through the web-site. The web-site gives you the ability to file claims on-line and print off a completed reimbursement form for submission. You will also have all the necessary program forms available on-line for your use. The site also provides you with detailed up to-the-minute account information.

As part of your FSA program, you will receive a MBI Debit Card. We encourage you to take advantage of this exciting approach in managing your FSA. The FSA Debit Card is a special MasterCard® that draws on the value of your annual Health Care FSA and/or Dependent Care election amount. Each time you incur a qualified expense not covered by your regular health insurance at a business that accepts MasterCard®, you can use the Flex Debit Card. Your qualified expenses will be deducted from your FSA automatically; your only responsibility will be to keep your receipts in case they are required per IRS guidelines (see below). The Flex Debit Card frees you from spending money out-of-pocket at the time of purchase and waiting for reimbursement checks for the vast majority of expenses.

The MBI MasterCard® Card provides THE MOST CONVENIENT WAY to access your FSA contributions.

HERE'S A LOOK AT REIMBURSEMENT		
Let's assume you...	**Paying for services out of pocket you would...**	**With MBI you will...**
Contribute $1,000 in one year to your Health Care FSA Account (or $19.50 a week)		
Purchase a prescription (or several prescriptions) at the pharmacy, or pay a copay at the doctor's office.	1. Pay what you owe. 2. Save the receipt. 3. Get a claim form. 4. Complete the claim form 5. Make a copy of your receipt and claim form for your records. 6. Submit the form and receipt for reimbursement via fax or US mail to BenefitElect and you will receive reimbursement 7. Wait for reimbursement via mail/direct deposit.	1. Swipe your MBI MasterCard® 2. Save the receipts! You will be notified if receipts are required (see below). If so, use the notification sent to you as a cover sheet when returning required receipts. Receipts can also be sent in anytime along with a Debit Card Receipt Transmittal Form attached below. **Funds are automatically deducted from your account!**

The Inventory Information Approval System (IIAS) is now available through the MasterCard network. The IIAS was designed to identify eligible healthcare purchases by comparing the UPC or SKU number for the items being purchased against a pre-established list of eligible medical expenses at the point of purchase thereby eliminating the need to submit receipts at participating retail providers (please visit http://www.sig-is.org/imwp/download.asp?ContentID=12418 for a real-time updated list of approved providers). Receipts for non- IIAS providers will still be required except for payment of solid dollar insurance co-payments and deductibles as well as same dollar amount expenses (i.e. –prescription renewals). Notifications will be sent to you if a receipt is required.

Items will be deemed Post Tax until the receipts are received. Those participants, who do not respond to a receipt substantiation notification within 90 days from request, could be subject to card suspension. All responses to notifications must be received within 6 business days after the plan year-end or the corresponding debit card transactions may be reclassified post tax for IRS reporting purposes. All non-eligible debit card claims will also be classified as post tax for IRS reporting purposes.

CLAIM FILING INSTRUCTIONS FOR HEALTH CARE EXPENSES

1. The total annual election for eligible medical expenses (less any previous reimbursements paid) may not exceed the maximum allowed under the plan. Please review your Summary Plan Document or see your Plan Administrator for more information.
2. Refer to the provisions in your Summary Plan Document for the minimum and maximum annual election amounts.
3. Valid reimbursement claims must include a fully itemized bill including the date of service, name of claimant, type of service, etc. from a doctor, dentist, pharmacy or other supplier, or an explanation of benefit statement indicating the deductible, co-insurance and amounts not covered by any medical/dental plan(s) (net of any amounts that have been or are to be paid by insurance or other sources).
4. Internal Revenue Service Publication 502 lists the eligible tax-free expenses. An eligible expense means any item for which you could have claimed a medical expense deduction on an itemized federal income tax return for which you have not otherwise been reimbursed from insurance, or some other source. The expenses must be incurred by you or your dependents while participating in the plan and not when they are billed to you.

CLAIM FILING INSTRUCTIONS FOR DEPENDENT CARE EXPENSES

1. The maximum amount you can be reimbursed during the time you are covered in the plan year cannot exceed the salary reduction amounts you have elected and made under the dependent care spending account less any previous reimbursements paid.
2. Reimbursement payments can be made for services provided in or outside your home for dependent child or adult dependent care in order for you and your spouse to work or go to school full time.
3. Your Maximum contribution amount cannot be more than the lesser of:
    - Your income or your spouse's income, whichever is less. If your spouse is a full-time student or incapable of self-care, your spouse is considered to earn $2400 per year with 1 dependent or $4800 a year with 2 or more dependents.
    - $5,000 per year if your tax filing status is "married filing jointly" or "single head of household" or $2,500 per year if your tax filing status is "married filing separately".
4. All expenses for dependent care must be for "Care". Expenses for Kindergarten, 1st grade, and above are not eligible for reimbursement according to the Internal Revenue Service. Coverage only applies to:
    - Dependents under the age of thirteen
    - Dependent adults or children thirteen years old or older who are mentally or physically incapable of self-care.
5. An itemized bill, receipt or contract must be submitted for reimbursement, which includes:
    - The dependent’s name
    - The period during which the services were rendered
    - The name, address and taxpayer ID number of the individual or organization providing services
    - A description of the service provided
    - Alternatively, for dependent care, if the above information is documented on the reimbursement form, you may have the provider sign the reimbursement form in lieu of a receipt.

NOTE: *Cancelled checks, credit card receipts, invoices or balance due statements are not valid proof of service for Dependent Care Expenses. More information on allowable claims can be found on our above referenced website.*

IMPORTANT

Flexible Spending Account Information

Health FSAs and HRAs will not be able to reimburse over-the-counter (OTC) medicines or drugs (other than insulin) without a doctor's prescription; similar restrictions will apply to HSAs and Archer MSAs. Both of these changes are effective for taxable years beginning after December 31, 2010.

Over the Counter Drugs

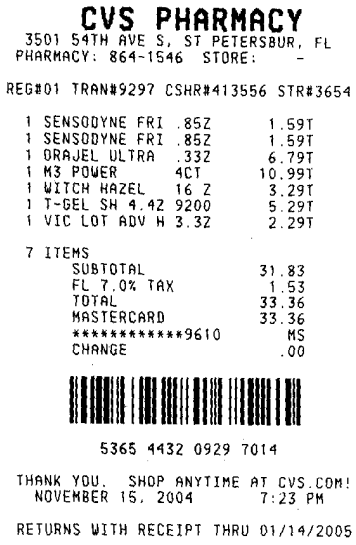
The IRS considers OTC drugs and medications to be reimbursable expenses through 12/31/2010. The ruling states that:

1. Reimbursements by an employer of **amounts paid by an employee for medicines and drugs purchased by the employee without a physician's prescription are** excludable from gross income (meaning it's **an eligible FSA expense!**)**."** In order to be reimbursed, these items must meet the definition of "Medical Care". "Medical Care" is defined as amounts paid for the diagnosis, mitigation, treatment or prevention of a disease, illness, or medical condition.

2. **However, amounts paid by an employee for dietary supplements (e.g., vitamins)** that are merely beneficial to the general health of the employee or the employee's spouse or dependents, **are not reimbursable** or excludable from gross income under Code 105(b).

You must include copies of your OTC drug receipts with your claim/transmittal form in order to receive reimbursement. Receipts submitted for reimbursement of OTC drugs must indicate the actual names of the OTC drugs.

This receipt displays a line item description indicating which OTC drugs were purchased.



CVS PHARMACY
3501 54TH AVE S, ST PETERSBUR, FL
PHARMACY: 864-1546 STORE: -

REG#01 TRAN#9297 CSHR#413556 STR#3654

1 SENSODYNE FRI	.85Z	1.59T
1 SENSODYNE FRI	.85Z	1.59T
1 ORAJEL ULTRA	.33Z	6.79T
1 M3 POWER	4CT	10.99T
1 WITCH HAZEL	16 Z	3.29T
1 T-GEL SH 4.4Z	9200	5.29T
1 VIC LOT ADV H	3.3Z	2.29T

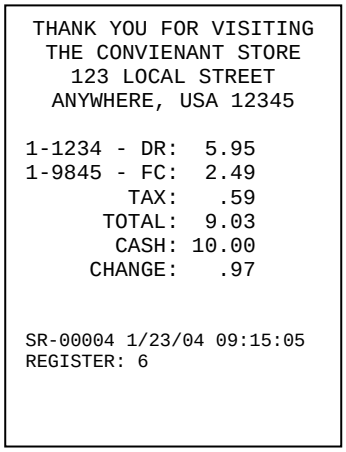
7 ITEMS

SUBTOTAL	31.83
FL 7.0% TAX	1.53
TOTAL	33.36
MASTERCARD	33.36
**********9610	MS
CHANGE	.00

5365 4432 0929 7014

THANK YOU. SHOP ANYTIME AT CVS.COM!
NOVEMBER 15, 2004 7:23 PM

RETURNS WITH RECEIPT THRU 01/14/2005



THANK YOU FOR VISITING
THE CONVIENANT STORE
123 LOCAL STREET
ANYWHERE, USA 12345

1-1234 - DR:	5.95
1-9845 - FC:	2.49
TAX:	.59
TOTAL:	9.03
CASH:	10.00
CHANGE:	.97

SR-00004 1/23/04 09:15:05
REGISTER: 6

This receipts displays unidentifiable line items that do not indicate OTC items purchased. Items from this receipt would not be reimbursable.

If you have questions, please contact BenefitElect at ***(800) 257-0986 (toll free)***

Submit your claim form and all supporting documentation via US mail, E-mail or a **dedicated claims fax line,** which insures confidentiality, to our Claims Processing Center at:

FAX #:866-395-4543
E-Mail: customerservice@chappellebenefits.com
US Mail: Claims Processing Center
P.O. Box 59548
Birmingham, AL 35259

FOR FASTER PROCESSING, FAX this Form and Receipts to: 866-395-4543
or Mail Form and Receipts to:
Chappelle Benefits
P.O. Box 59548 Birmingham, AL 35259
(PLEASE KEEP YOUR ORIGINALS)

BenefitElect
A Division of Chappelle Consulting Group, Inc.

Questions?
Email us at:
customerservice@chappellebenefits.com
or call us at 800-257-0986

CLAIM REIMBURSEMENT FORM

(Not for FSA Debit Card Receipts)

FSA CLAIM REIMBURSEMENT REQUEST FORM - Receipts received with this form will be processed for reimbursement. *Do not use this form for submitting FSA Debit Card Purchase Receipts* - use the forms in your enrollment/confirmation kit or download those from the web.

Employee Name _____ **Employee ID / SSN:** _____

Daytime Phone Number_____ **Email Address** _____

Employer Name _____

Health Care Reimbursement Claim (HCRA-non-reimbursed medical) - You MUST attach a bill, receipt or Explanation of Benefits (EOB) verifying the date of service or product, type of service or product, name of person receiving service and amount claimed.

Date of Service	Type	For Whom (name and relationship)	Amount
1. _____	_____	_____	$_____
2. _____	_____	_____	$_____

If you have more items to list, please use page 2 of this claim form.

Dependent Care Reimbursement Claim (DCRA) - You MUST attach a bill or receipt from your dependent care provider verifying the dependent's name, name, address and taxpayer ID number (SSN or TIN) of provider, period which services were rendered, description of services and amount. If the Dependent Care Provider signs the appropriate area below, receipts are not required.

Date of Service	Dependent's Name, Relationship and Date of Birth	Provider's Name and Address	Provider's Tax ID/SSN	Amount
1. _____	_____	_____	_____	$_____
2. _____	_____	_____	_____	$_____

PROVIDER CERTIFICATION: I hereby certify that the above Dependent Care charges have been incurred.

Dependent Care Provider Signature _____ Date _____

If you have more items to list, please use page 2 of this claim form.

Healthcare Reimbursement Arrangement (HRA) - You MUST attach a bill, receipt or Explanation of Benefits (EOB) verifying the date of service or product, type of service or product, name of person receiving service and amount claimed.

Date of Service	Type	For Whom (name and relationship)	Amount
1. _____	_____	_____	$_____
2. _____	_____	_____	$_____

Outside Premium Reimbursement Account (OPRA) - Attach a bill or receipt indicating the non-company premium healthcare payment

Date of Service	Type	For Whom (name and relationship)	Amount
1. _____	_____	_____	$_____
2. _____	_____	_____	$_____

I hereby certify that all items I requested to be reimbursed comply with the Flexible Spending Account Plan and such items have not and will not be covered by any other plan or program of any employer or other person nor have these items been paid for by a debit card or stored value card offered with the Flexible Spending Account Plan. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The company does not accept responsibility for direct payment to any individuals other than the employee.
*Participant Signature X*_____ *Date* _____

*** IF YOU DON'T HAVE ONLINE ACCESS TO YOUR ACCOUNT, PLEASE PROVIDE YOUR EMAIL ABOVE AND CHECK THIS BOX [ ] - WE WILL EMAIL INSTRUCTIONS. ***

FOR FASTER PROCESSING, FAX this Form and Receipts to: 866-395-4543
or Mail Form and Receipts to:
Chappelle Benefits
P.O. Box 59548 Birmingham, AL 35259
(PLEASE KEEP YOUR ORIGINALS)

BenefitElect
A Division of Chappelle Consulting Group, Inc.

Questions?
Email us at:
customerservice@chappellebenefits.com
or call us at 800-257-0986

CLAIM REIMBURSEMENT FORM – Page 2

(Not for FSA Debit Card Receipts)

FSA CLAIM REIMBURSEMENT REQUEST FORM - Receipts received with this form will be processed for reimbursement. *Do not use this form for submitting FSA Debit Card Purchase Receipts* - use the forms in your enrollment/confirmation kit or download those from the web.

Employee Name _____ **Employee ID / SSN:** _____

Daytime Phone Number_____ **Email Address** _____

Employer Name _____

Health Care Reimbursement Claim (HCRA-non-reimbursed medical) - You MUST attach a bill, receipt or Explanation of Benefits (EOB) verifying the date of service or product, type of service or product, name of person receiving service and amount claimed.

	Date of Service	Type	For Whom (name and relationship)	Amount
3.	_____	_____	_____	$_____
4.	_____	_____	_____	$_____
5.	_____	_____	_____	$_____
6.	_____	_____	_____	$_____
7.	_____	_____	_____	$_____
8.	_____	_____	_____	$_____
9.	_____	_____	_____	$_____
10.	_____	_____	_____	$_____

Dependent Care Reimbursement Claim (DCRA) - You MUST attach a bill or receipt from your dependent care provider verifying the dependent's name, name, address and taxpayer ID number (SSN or TIN) of provider, period which services were rendered, description of services and amount. If the Dependent Care Provider signs the appropriate area below, receipts are not required.

	Date of Service	Dependent's Name, Relationship and Date of Birth	Provider's Name and Address	Provider's Tax ID/SSN	Amount
3.	_____	_____	_____	_____	$_____
4.	_____	_____	_____	_____	$_____

PROVIDER CERTIFICATION: I hereby certify that the above Dependent Care charges have been incurred.

Dependent Care Provider Signature _____ Date _____

I hereby certify that all items I requested to be reimbursed comply with the Flexible Spending Account Plan and such items have not and will not be covered by any other plan or program of any employer or other person nor have these items been paid for by a debit card or stored value card offered with the Flexible Spending Account Plan. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The company does not accept responsibility for direct payment to any individuals other than the employee.

*Participant Signature X*_____ *Date* _____

FOR FASTER PROCESSING, FAX this Form and Receipts to: 866-395-4543
or Mail Form and Receipts to:
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P.O. Box 59548 Birmingham, AL 35259
(PLEASE KEEP YOUR ORIGINALS)

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Questions?
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or call us at 800-257-0986

mbi MasterCard DEBIT CARD RECEIPT TRANSMITTAL COVER SHEET

Your compliance is required to meet IRS required FSA Debit Card receipt review

Use this cover sheet if you are faxing or mailing *mbi* MasterCard Receipts. This is not a claim reimbursement form. Reimbursements will not be processed if this form is used.

Employee Name_____ Employee ID / SSN _____-___-____

Daytime Phone Number_____ Email Address _____

Employer Name_____MBI MasterCard Number _____

Attach copies of your receipts with this cover sheet. Acclaris will receive your FAX and secure the content according to HIPAA Privacy requirements. Be sure that you or others on your behalf secure your data at the point of origination. Original receipts will not be returned. Note: The customer is responsible for misrepresentation regarding requests for reimbursement. If you have any further questions please contact customer service.

Date and incurred costs

	Transaction Date	Merchant Name	For Whom (name and relationship)	Amount
1.	_____	_____	_____	$_____
2.	_____	_____	_____	$_____
3.	_____	_____	_____	$_____
4.	_____	_____	_____	$_____
5.	_____	_____	_____	$_____
6.	_____	_____	_____	$_____

Use additional sheet(s) if necessary **TOTAL AMOUNT OF ATTACHED RECEIPTS** **$**_____

I certify that I am authorized to use the MasterCard issued and that by signing and using the debit card, I agree to all terms and conditions. I understand that any transactions initiated by my use of an authorized Card are subject to the terms and conditions of the Cardholder Agreement received with the Card. I certify that the qualified healthcare expenditures presented with this transmittal have been received by an eligible individual and are true and accurate. I further certify that these expenses have not, nor will be, reimbursed through insurance or any other arrangement.

Participant Signature X_____ **Date** _____

FOR FASTER PROCESSING, FAX or e-mail this form to: 866-395-4543
or Mail Form and Receipts to:
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P.O. Box 59548 Birmingham, AL 35259
(PLEASE KEEP YOUR ORIGINALS)

BenefitElect
A Division of Chappelle Consulting Group, Inc.

Email us at:
customerservice@chappellebenefits.com
or call us at 800-257-0986

Direct Deposit Form

If you choose to receive your direct deposit to your bank account, please complete this form and return it with your Enrollment form to your company's benefits administrator.

You must attach a copy of a voided check for a checking account deposit, or a deposit slip for a savings account deposit in the designated space below. If you choose a savings account deposit, please verify the bank's routing number – the number on your deposit slip may not be the correct number for direct deposit transactions.

Company Name:	**Plan Year:**

Employee Information

Employee Name:	**Social Security #:**

Account Information

Bank Name:	**Type of Account (circle): CHECKING SAVINGS**
Bank Routing Number: (see diagram below)	**Bank Account Number: (see diagram below)**

Authorization

I authorize the direct deposit of funds reimbursed from my Pre-tax Accounts into the bank account specified above. My administrator will continue to use this as my "Account of Record" until notified, in writing, to discontinue use of the account. I understand that direct deposit will continue automatically into each new Plan Year unless I notify my administrator, in writing, of a change. I authorize my bank account to be debited for any reimbursements sent in error or claims denied after reimbursement. I certify that I have read, and understand, the information on this Authorization form.

Signature: _____ **Date:** _____

Attach a COPY of a Voided Check