Online Open Enrollment

Please follow the instructions below to use online open enrollment through your benefit portal. PLEASE skip step one if you are already a participant on the FSA and have an account already created.

Step 1 – New Participants Only – SKIP if already registered or send e-mail to support@bbpadmin.com to reset password.

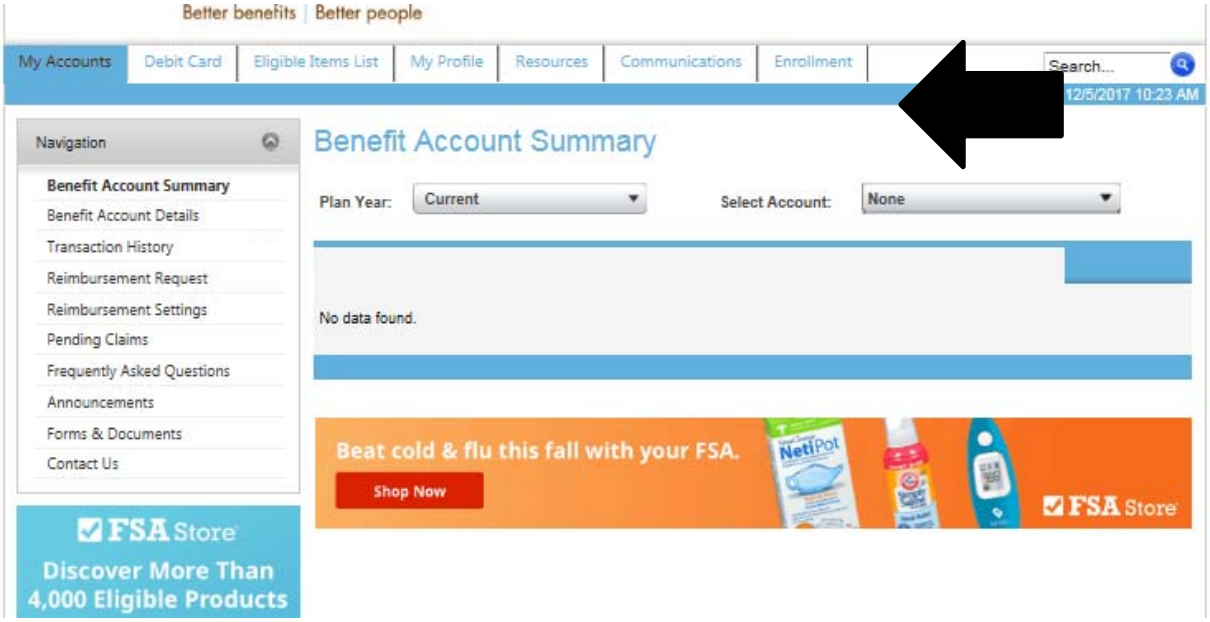
To access the system, go to www.mywealthcareonline.com/bbp

Click on Register.

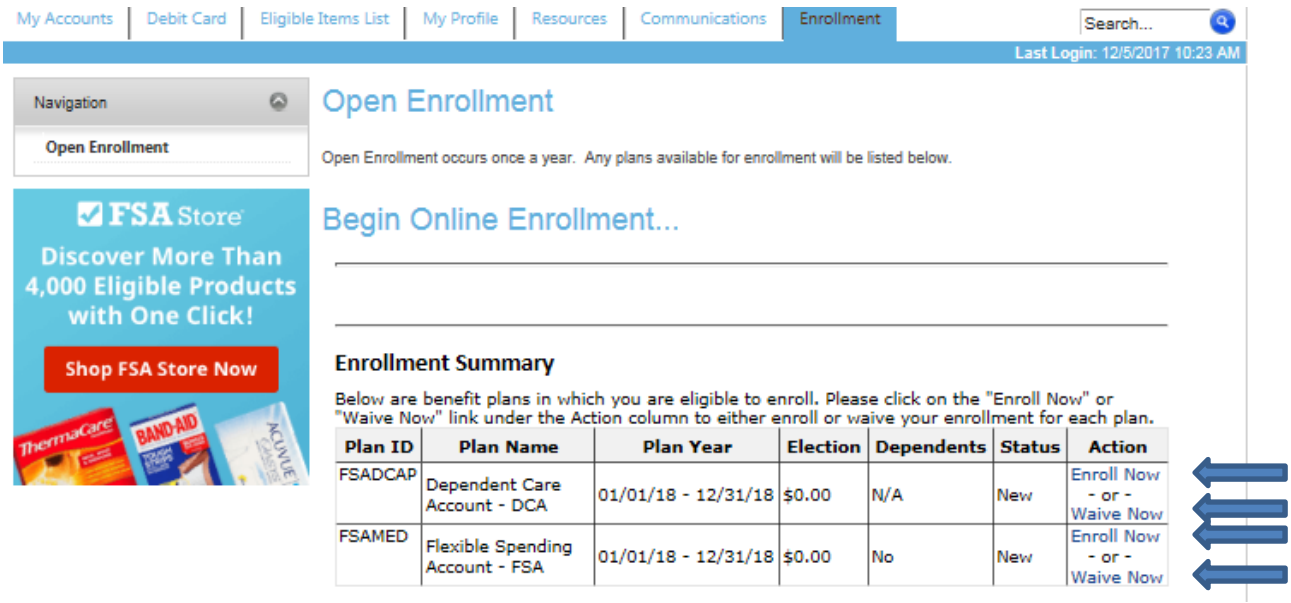
- Please enter a user name.
- Please enter your first name.
- Please enter your last name.
- Please enter your e-mail address.
- Please create a password.
- Please retype your password.
- Please enter your Employee ID. Your employee id is: **Social Security Number** (no dashes)
- Please enter your Employer ID. Your employer id is: **Please See Open Enrollment E-mail for your Employer ID** (this is case sensitive)
- Please check that you accept the Terms of Service.

You will then be asked to register your computer by completing answers to preset questions and then you will set-up a picture.

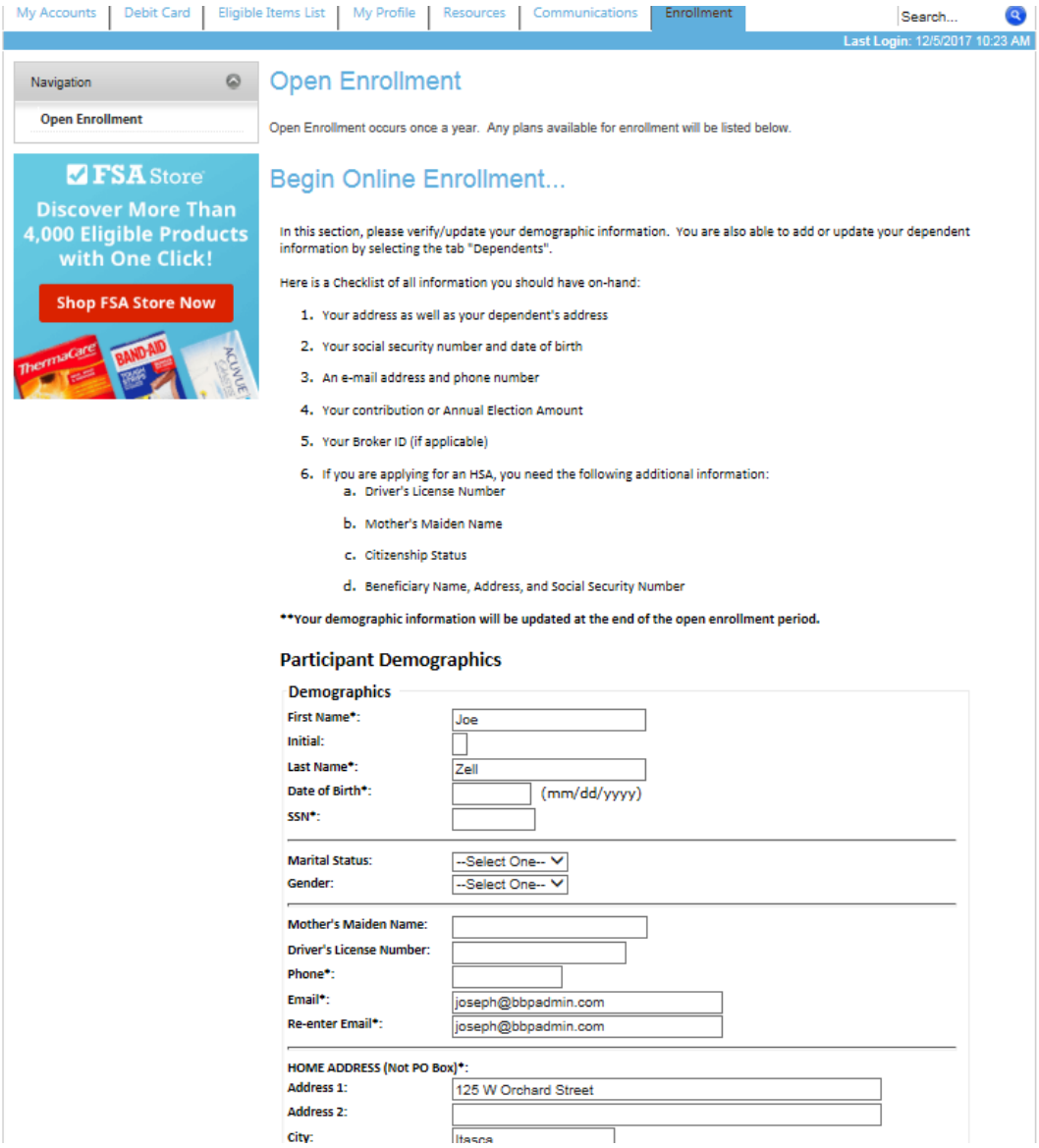
Step 2: Start Enrollment – Below is the home screen – please click enrollment



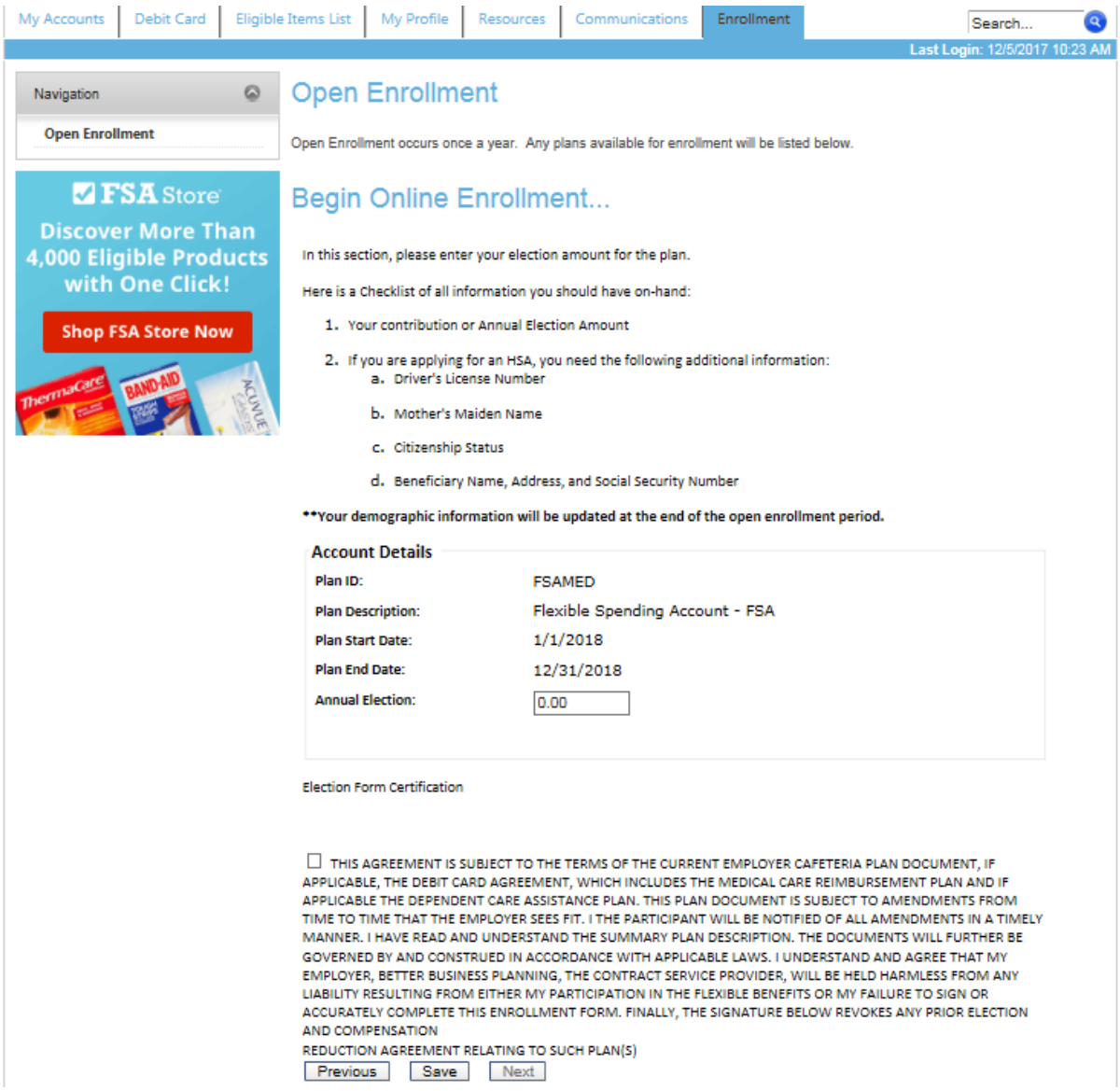
Step 3 – Enroll or Waive – Please either enroll or waive the benefit in which you would like.



Step 4 – Begin Enrollment Process – Please enter in your demographic information



Step 5 – Benefit Account – Please enter in the annual election of the account that you have chosen



Step 6 – Reviewing your application – Please review your open enrollment application, check all of the boxes, and enter in your electronic signature at the very bottom

Disclosures

Your employer and Better Business Planning, Inc. want you to be aware of the following documents. Under the participant portal under Forms & Documents you will see many documents that explain this plan in detail. Please go to this section and review the Summary Plan Description, enrollment kit, claim kit and enrollment form. In addition, please be aware if your employer uses the debit card option that you have read that agreement. If you have any questions, please call 630-773-2228 or e-mail support@bbp-dac.com.

☑ I acknowledge the disclosures by my employer and Better Business Planning and agree to the terms.

Agreements

OTHER TERMS AND CONDITIONS

I understand that:

- My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for the new plan year.
- I cannot participate in the dependent day care reimbursement account if I am receiving the Earned Income Credit. Also, because of IRS discrimination testing, if your total compensation will be greater than $110,000, or you own stock in the company you work for, your election may be reduced or canceled.
- Prior to the first day of each plan year I will be offered the opportunity to change my benefit election for the following plan year during this Plans open enrollment.
- I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a change in family status; including but not limited to, marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of spouse's employment or such other events as the plan administrator determines will permit a change or revocation of an election per IRS law.
- The plan administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code and Discrimination Rules.
- The reduction of my compensation under this agreement shall be in addition to any reduction under other agreements or benefit plans.

☑ Check - I Understand

I further understand that:

- The amount of my compensation reduction will be credited to a medical care reimbursement account and/or dependent care assistance account and such amount will be reimbursed, up to the balance in that account, for the applicable expenses incurred during the year.
- I understand that monies placed in the dependent care assistance plan cannot be used to pay for eligible medical expenses and vice versa.
- Any amounts that are not used during a plan year to provide benefits will be forfeited and may not be paid to me in cash. I will have until the end of the grace period to incur claims (if applicable) and up until the plan close out date to have claims postmarked and send to Better Business Planning.
- At retirement, my social security and Medicare benefits may be slightly reduced as a result of my election.
- If I or any Family Member Participates in a Health Reimbursement Account, Health Savings Account, or Medical Savings Account, I cannot be double reimbursed through a Flexible Spending Account. Second, I will notify Employer and Better Business Planning of said participation in these plans.
- I can submit Reimbursements for all eligible dependents that I list on my tax return for the same year.

☑ Check - I Understand

REIMBURSEMENTS

I understand that:

- The reimbursement will be available only for "qualifying health care or dependent care expenses" as described in the Summary Plan Description. I agree to notify Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse Employer on demand any liability it may incur for failure to withhold federal, state, or social security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by either myself or Employer.
- This agreement will automatically terminate if the Plan is terminated or discontinued.
- If I cease my employment with Employer, my participation in the Plan will continue if available by law.
- I cannot seek reimbursement from this account for a medical expense that I intend on taking as a deduction or credit on my tax return or from another pre-tax plan.

☑ Check - I Understand

I have received a copy of my Employer's Summary Plan Description for this plan. I understand this document and I understand my employer's plan year and the date of service rule. I further understand the run out period and the use it or lose it rule of my employer's plan.

☑ Check - I Understand

I understand if my employer offers a debit card the IRS has additional rules that govern debit card usage. I will be required to submit additional receipts or my debit card will be shut off. I also have received a copy of the debit card agreement.

☑ Check - I Understand

Electronic Signature

THIS AGREEMENT IS SUBJECT TO THE TERMS OF THE CURRENT EMPLOYER CAFETERIA PLAN DOCUMENT, IF APPLICABLE, THE DEBIT CARD AGREEMENT, WHICH INCLUDES THE MEDICAL CARE REIMBURSEMENT PLAN AND IF APPLICABLE THE DEPENDENT CARE ASSISTANCE PLAN. THIS PLAN DOCUMENT IS SUBJECT TO AMENDMENTS FROM TIME TO TIME THAT THE EMPLOYER SEES FIT. I THE PARTICIPANT WILL BE NOTIFIED OF ALL AMENDMENTS IN A TIMELY MANNER. I HAVE READ AND UNDERSTAND THE SUMMARY PLAN DESCRIPTION. THE DOCUMENTS WILL FURTHER BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS. I UNDERSTAND AND AGREE THAT MY EMPLOYER, BETTER BUSINESS PLANNING, THE CONTRACT SERVICE PROVIDER, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN THE FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. FINALLY, THE SIGNATURE BELOW REVOKES ANY PRIOR ELECTION AND COMPENSATION REDUCTION AGREEMENT RELATING TO SUCH PLAN(S).

First Name*	Last Name*	Date Signed
		12/5/2017
Confirm First Name*	**Confirm Last Name***	

Submit Application