Representative Payee Services

Client Intake Packet

BENEFITS MANAGEMENT CORPORATION / LIFE
2640 Cordova Lane, Suite 101
Rancho Cordova, CA 95670
P.O. Box 168045 Sacramento, CA 95816

1047 North 4th Street
San Jose, CA 95112
P.O Box 11012 San Jose, CA 95103

Toll Free Phone: 866-622-3098 Toll Free FAX: 866-606-3248
Website: www.webpayee.com

Benefits Management CORPORATION

Living In Familiar Environments

Benefits Management CORPORATION Living In Familiar Environments

Benefits Management Corporation and
Living in Familiar Environments
2640 Cordova Lane • Ranch Cordova, CA 95670
1047 North 4th Street • San Jose, CA 95112
www.webpayee.com * Phone (866) 622-3098 * Fax (866) 606-3248

Instructions for Completing the Client Intake Packet

1. Complete all of the forms included in this document and ensure client signs where designated. (The Budget Worksheet is optional – See #5 below).

2. If this is the first time the client is applying for a Representative Payee, please download and complete the SSA 787 Form (Physician's Statement of Patient's Capability to Manage Benefits). If the Social Security Administration has already determined client must have a representative payee, completing a SSA-787 is not necessary.

3. Obtain and submit 2 forms of identification – preferably 1 photo I.D. and 1 other form of I.D. such as:
   a. CA driver license, CA Identification Card, Veterans' Administration Identification
   b. Social Security Card

4. If possible, provide a copy of the client's Medi-Cal Card.

5. In order to assist in developing an accurate budget, please provide copies of the following bills, if applicable:
   a. Rental agreement – it is ***vital*** we receive this document immediately. Without a rental agreement, Social Security benefits can be delayed.
      i. (if you do not have a rental agreement, you may download one from the resources page of our website. www.webpayee.com)
   b. Utilities such as SMUD and/or P G & E
   c. City or county water, sewer & garbage bills

6. You may complete and submit budget worksheet yourself/with your client. This is helpful if you/your client has bills such as cell phone or auto insurance that will be paid out of personal and incidental funds making it is necessary to have those funds dispersed at a particular time of month. The Benefits Management Corp / LIFE staff will review the worksheet you submit and work with you/your client if adjustments are necessary to ensure benefit lasts for the entire month.

7. 7.Ensure client receives a copy of the last four pages of the intake packet for his/her records:
   Client Agreement, Processes and Procedures, What Happens During Intake, What Happens After I Sign Up

8. 8.Fax the completed intake packet to: 866-606-3248 or you may submit via email to: agency@webpayee.com.

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Client Intake Packet CHECK LIST

1. **BMC Does Not Accept Clients with the following items**:

   - **1.1.** ☐ Clients with a mortgage balance; or
   - **1.2.** ☐ Clients with a large amount owed to personal back taxes.
     - **1.2.1.** ☐ Disclose all back owed tax details upfront to BMC to determine eligibility.

2. **BMC May Accept Clients with the following items after careful review of income to debt ratio and/or willingness of creditor to work within client's means**:

   - **2.1.** ☐ Property Tax on a free and clear home
   - **2.2.** ☐ Large Unpaid Medical Bill

3. **BMC Accepts Clients with the following and BMC is Responsible for Making Payments. Please disclose any back owed amounts to BMC UP FRONT**:

   - **3.1.** ☐ Garbage Bill
   - **3.2.** ☐ Land Line Telephone Bill
   - **3.3.** ☐ Medical Bill
   - **3.4.** ☐ P G & E Account
   - **3.5.** ☐ SMUD Account
   - **3.6.** ☐ Unpaid Fine

4. **BMC Accepts Clients with the following and Client is Responsible for Making Payments**:

   - **4.1.** ☐ Auto Loan Payments
   - **4.2.** ☐ Auto Insurance
   - **4.3.** ☐ Cable Bill
   - **4.4.** ☐ Cell Phone Bill
   - **4.5.** ☐ Credit Card Bill
   - **4.6.** ☐ Debt Collections
   - **4.7.** ☐ Furniture Rentals
   - **4.8.** ☐ Internet Bill
   - **4.9.** ☐ Medical Bill
   - **4.10.** ☐ Pawn Shop Loans
   - **4.11.** ☐ Pay Day Loans
   - **4.12.** ☐ Personal Storage Bill

NOTE: BMC will make payments for clients who are supported closely by an agency, e.g. ALTA, Sutter Senior Care, or Solano County Mental Health. Please ask for more details.

CLIENT INTAKE

Date: ____________________

LAST NAME FIRST MI	SOCIAL SECURITY NUMBER
DATE OF BIRTH	PLACE OF BIRTH
REFERRING AGENCY	CONTACT PERSON PHONE NUMBER
AGENCY WEBSITE	CONTACT PERSON EMAIL

LIVING ARRANGEMENT

C/O

Telephone Number

Street Address

Move In Date

City, State, Zip Code

Monthly Rent Amount

Do you live alone? ☐ **Yes** ☐ **No**

If no, whom do you live with?

NAME RELATIONSHIP

NAME RELATIONSHIP

NAME RELATIONSHIP

NAME RELATIONSHIP

NAME RELATIONSHIP

NOTES:____

Version 3.5 15-09-18

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INCARCERATION

JAIL / PRISON LOCATION: ______________________________

DATE IN: ____________________ DATE OUT: ____________________

X-REF#: ____________________ CDC#: ____________________

PAROLE / PROBATION OFFICE NAME: ______________________________

OFFICE TELEPHONE #: ______________________________

SOCIAL SECURITY INFORMATION

CLAIM REP: ____________________ CLAIM OFFICE: ____________________

BENEFITS: SSI: ____________________ SSA: ____________________

OVERPAYMENT: ☐ YES ☐ NO BALANCE: ____________________

RESOURCES: ______________________________

____

____

FROM OUT OF STATE: ☐ YES ☐ NO

DATE ENTERED STATE? ____________________ PROOF OF ENTRY: ☐ YES ☐ NO

NEW CLAIM

SSA OFFICE: ____________________ REP: ____________________

NOTES: ______________________________

____

____

ATTORNEY: ☐ YES ☐ NO NAME: ____________________

PHONE #: ____________________

Benefits Management CORPORATION
Living In Familiar Environments

OTHER BENEFITS

VA: $____________ CLAIM#: ________ RRR: $________________ CLAIM# ____________________

OTHER: NAME ______________________ $ ________________ CLAIM# ___________________________

OTHER: NAME ______________________ $ ________________ CLAIM# ___________________________

UNEARNED INCOME

CHECK ALL THAT APPLY

- ☐ PRIVATE PENSION
- ☐ AFDC / GA / FOODSTAMPS
- ☐ RENTAL INCOME
- ☐ UNEMPLOYMENT
- ☐ ALIMONY
- ☐ CHILD SUPPORT
- ☐ DIVIDENDS
- ☐ ROYALTIES
- ☐ TRUST FUND

WAGES

☐ YES ☐ NO EMPLOYER: ____

CONTACT INFO: ____

REMIND CLIENT TO TURN IN COPIES OF PAYSTUBS MONTHLY. IF NOT TURNED IN TO SSA, THIS MAY CAUSE AN OVERPAYMENT AND A LARGE WAGE ESTIMATE ON THE CLIENT'S RECORD. GIVE CLIENTS STAMPED ENVELOPES

RESOURCES

THE RESOURCE LIMIT IS $2000 FOR A SINGLE PERSON AND $3000 FOR A MARRIED COUPLE. THE LIMIT APPLIES TO SSI AND MEDI-CAL ONLY

Mark All that Apply

- ☐ CHECKING ACCOUNT **GET BANK NAME AND ACCT#**
- ☐ SAVINGS ACCOUNT **GET BANK NAME AND ACCT#**
- ☐ CREDIT UNION **GET NAME AND ACCT#**
- ☐ TRUST
- ☐ STOCKS / BONDS
- ☐ CHRISTMAS CLUB
- ☐ REAL ESTATE
- ☐ BURIAL PLOT
- ☐ LIFE INSURANCE
- ☐ CAR / MOTORCYCLE
- ☐ BOAT
- ☐ TRAILER

WILL / BURIAL

☐ YES ☐ NO
(Get copy of this information for the file)

TYPE: ______________________________

WHEN ESTABLISHED: ______________________________

VALUE: ______________________________

CONSERVED

IS THE CLAIMANT CONSERVED? ☐ YES ☐ NO

CONSERVATOR NAME: ______________________________

CONSERVATOR ADDRESS: ______________________________

____

PHONE#: ______________________________

MARITAL STATUS / CHILDREN

☐ SINGLE ☐ MARRIED (DATE: _________) ☐ SEPERATED (DATE: ___________)

☐ DIVORCED (DATE: __________) ☐ ANNULLED (DATE: ____________)

☐ WIDOWED (DATE: ___________)

CHILDREN? ☐ YES ☐ NO IF YES, HOW MANY? ______________________

EMERGENCY CONTACTS

NAME	NAME
STREET ADDRESS	STREET ADDRESS
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
TELEPHONE	TELEPHONE
RELATIONSHIP	RELATIONSHIP

OTHER CONTACTS

NAME	NAME
STREET ADDRESS	STREET ADDRSS
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
TELEPHONE	TELEPHONE
RELATIONSHIP	RELATIONSHIP

IDENTIFICATION

GET A COPY OF THE FOLLOWING FOR FILE:

- ☐ PHOTO ID
- ☐ SSA CARD
- ☐ MEDI- CAL CARD
- ☐ OTHER ID

Advance Notification of Representative Payment

Name of Wage Earner, Self-Employed Person or SSI Claimant	Social Security Number
	— —
Name of Beneficiary (if other than above)	Relationship to Wage Earner, Self-Employed Person or SSI Claimant

I understand and agree with the following.

Need for Representative Payee

The Social Security Administration (SSA) has decided that I need someone to manage my benefits. Because of this, SSA will send my benefits to a representative payee. It is the duty of the representative payee to use my benefits for my best interests.

Choice of Representative Payee

SSA has selected ____ to be my representative payee.

My Right to Appeal

I understand that I have the right to appeal SSA's decision. I can appeal the choice of who will be the representative payee. In most cases, I can also appeal the decision that I need a payee. If I appeal, I will have the right to review the evidence in file and submit new evidence. I understand that I can have a friend, lawyer or someone else to help me.

I understand that I must file an appeal within 60 days. If I file after the 60 day period, I must have a good reason for not having filed this appeal on time. I have to ask for the appeal in writing. I will contact an SSA office if I wish to appeal.

______________________________ ______________________

Signature Date

Witnesses are required only if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

Form SSA-4164 (9-1994) ef (5-2005)
Destroy Prior Editions

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Consent to Release Information

To: Benefits Management Corporation and Living in Familiar Environments

Name:______________________________ Date of Birth: ____________________

SSN: ______________________________

I hereby give my consent to **Benefits Management Corp / L.I.F.E.** to obtain and/or exchange information for the purpose of either planning for my well-being and/or assuring my continuing eligibility for Social Security benefits.

I also hereby give my consent to **BMC / L.I.F.E.** to obtain and/or exchange information regarding the item(s) below for the purpose of planning for my well-being.

☐ Social Security Number	☐ Account Ledger	☐ Current Monthly SSA/SSI
☐ Bank Account	☐ Burial Trust	☐ Medi-Cal
☐ Wages/Employment Record	☐ Social History	☐ Utility Bills
☐ O.H.S. Plan / Appointments	☐ Address/Living Arrangement	☐ Other (explain below)

____

____

I am the individual, to whom the requested information/records applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare that I have examined all of the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that BMC / LIFE is not responsible if a person authorized to obtain information regarding my account does so with false pretenses and BMC / LIFE is not responsible for any effect to your benefits caused by releasing the requested information.

______________________________ ______________________________
Print Name Date

______________________________ ______________________________
Signature of Claimant or Legal Guardian Relationship (if not claimant)

______________________________ ______________________________
L.I.F.E. Staff Member Date

	WHOSE *Records to be Disclosed* Form Approved OMB No. 0960-0623
	NAME *(First, Middle, Last)*
	SSN _ _ / Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange)**:**

OF WHAT ***All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY	IF not signed by subject of disclosure, specify basis for authority to sign
INDIVIDUAL authorizing disclosure	☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**
SIGN ▶	(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶	**IF** needed, second witness sign here (e.g., if signed with "X" above) **SIGN ▶**
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility, or continuing eligibility, for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose information:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to ensure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

SSA will not redisclose without proper prior written consent information: (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT

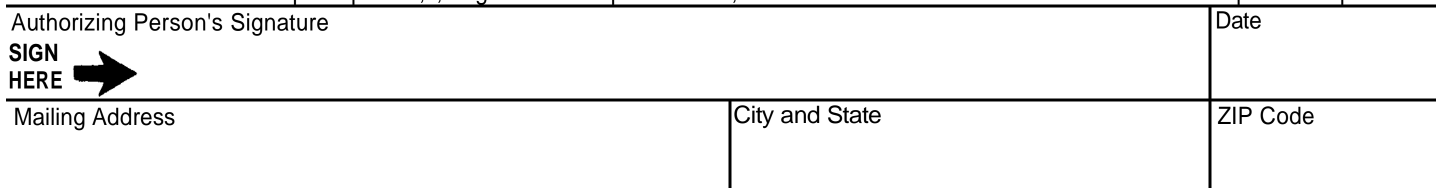
This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send **only** comments relating to our time estimate to this address, not the completed form.

AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN PERSONAL INFORMATION

Authorizing Person (Person about whom information is being requested)	Social Security Number

Claimant/Beneficiary (If other than authorizing person)	Claimant's/Beneficiary's Social Security Number

I authorize any public or private custodian of records to disclose to the Social Security Administration any records or information about me. In the case of a minor or incapable person, I, as guardian or representative, authorize the same disclosure of records about the person I represent.



Authorizing Person's Signature SIGN HERE	Date

Mailing Address	City and State	ZIP Code

Your authorization does not ordinarily have to be witnessed. However, if you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number, Street, City, State, ZIP Code)	Address (Number, Street, City, State, ZIP Code)

COLLECTION AND USE OF INFORMATION ON YOUR CONSENT FORM— PRIVACY ACT NOTICE

The Social Security Administration is authorized to collect the information on your consent form under sections 205(a) and 1631(e) of the Social Security Act, as amended (42 U.S.C. 405 and 42 U.S.C. 1383(e)). Giving us the information on this form is voluntary. You do not have to do it but benefits may not be payable unless you give us this information.

The Social Security Administration will use this form to get information to decide eligibility for payments. We may routinely give out the information obtained without your consent if:

1. We need to get more information to decide eligibility for benefits;
2. An agency needs this information to decide eligibility for a health or income program such as Supplemental Security Income (SSI), State supplementary payments, food stamps, Medicaid, energy assistance, Veterans benefits, railroad unemployment insurance, or Basic Educational Opportunity Grants;
3. A Federal law requires that we give out this information;
4. Your congressman or the President's Office needs this information to answer questions you ask them;
5. Someone needs this information to do statistical research or audit reports for us related to the Social Security programs; or,
6. The Department of Justice needs the information to represent the Federal Government in a court suit related to an SSA program.

These and other reasons why information about you may be used or given out are explained in the Federal Register. If you would like more information about this, get in touch with any Social Security office.

*U.S. Government Printing Office: 1998 - 433-335/80148

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Representative Payee Acknowledgement

I understand that by signing and submitting these documents, the Social Security Administration (SSA) may determine it necessary for me to have a representative payee and may appoint Benefits Management Corporation/Living in Familiar Environments to serve as such.

Note: On page 7 of the Social Security Administration's Guide for Organizational Representative Payees, SSA states, "SSA will never appoint a representative payee solely for a beneficiary's convenience or personal preference".

______________________________ ______________________________
Client Signature Date

______________________________ ______________________________
BMC / LIFE Staff Member Date

CLIENT AGREEMENT – Processes and Procedures

Supplemental Security Income (SSI) is a needs-based benefit. That means that the amount of money for which you are eligible is based on three things:

1. Your living arrangements
2. Other income/benefits you may receive
3. Your total resource, which are things you own. For example; bank accounts, stocks, bonds, homes, vehicles, jewelry, etc.

Benefits Management Corporation (BMC) and Living In Familiar Environments (L.I.F.E.) **will not** be held responsible for any overpayments due to your failure to notify our office of changes. **Notification of changes must be made in writing.** This can be done in person by visiting our office, by fax, email, or by mailing a **signed** letter to BMC/L.I.F.E.

IT IS VERY IMPORTANT TO NOTIFY US WITHIN 10 DAYS IF ANY OF THE ITEMS BELOW OCCUR.

RESIDENCE

- You move from your residence
- Someone permanently moves into or out of your residence
- You enter jail or prison (BMC/L.I.F.E. does not accept collect phone calls from jail or prison)
  - **Note: If you fail to notify us by phone, email, or mail and money is issued for rent, utilities and other expenses, BMC/L.I.F.E. is not responsible for any overpayment that occurs.**
- You change your phone number
- You enter or leave a hospital or skilled nursing facility.
- You leave the state of California.

RESOURCES

- The amount of alimony or child support you receive changes
- You inherit or are given money
- You open or close a bank account, and if you receive interest on the account
- The amount of any benefit checks you receive directly changes
- You receive money from another source (VA, Railroad Retirement, or pension)
- Your benefit from another source stops
- You start or stop working
  - **Note: If you work, you must provide copies of your wage stubs to BMC/L.I.F.E. to submit to the Social Security Administration. If you do not provide copies of your wage stubs and are overpaid, BMC/L.I.F.E. will not be held responsible.**
- Purchase a burial plot or make burial arrangements
- Purchase a life insurance policy on yourself or someone else
- Buy or sell any auto, truck, boat, motorcycle, RV, etc.
- Buy or sell any real estate, including a house, condo or mobile home

WHAT HAPPENS DURING THE INTAKE INTERVIEW AT BENEFITS MANAGEMENT CORPORATION AND LIVING IN FAMILIAR ENVIRONMENTS?

1. At the time of intake, the BMC/LIFE representative can tell you when BMC/L.I.F.E. will **expect** to begin receiving your benefits.
   - If the intake is completed before the Social Security Administration's "cut off" date for the month (this is usually the second Friday of each month) BMC/L.I.F.E. should receive your next month's benefits.
   - If your benefits are in suspense (your benefits are stopped for some reason), BMC/L.I.F.E. will work to get your benefits reinstated as quickly as possible.
   - If you are a new claimant, BMC/L.I.FE., will contact the Social Security Administration regularly until your benefits are approved and the Social Security Administration begins distributing your benefits.

2. You will be told who your Account Manager is and you will be provided with the Account Manager's contact information. The Account Manager is the person you will speak with regarding your budget and account. You will need to notify your account manage in the event any changes occur; such as moving, living arrangements, and phone number.

3. Your Account Manager has a voicemail box and email for you to contact them. Your Account Manager will return your voicemail or email messages as soon as possible. The office lobby is open 7:30am to 4:00pm Monday through Friday and closed on all federal holidays. It is important to leave full details on your voicemail message. Always leave your first and last name, social security number, phone number where you can be reached, and detailed reason for your call. **PLEASE LEAVE ONLY ONE MESSAGE PER DAY AND ALLOW THE ACCOUNT MANAGER TIME TO RETURN YOUR CALL.** Leaving multiple messages will only delay your return call.

4. If possible, your budget is established at the time of the intake. If we are unable to establish a budget at the time of your intake, you will need to contact your Account Manager to do so before BMC/L.I.F.E. can release your funds. You will need to provide a copy of your rental agreement and bills that you would like BMC/L.I.F.E. to pay before payment can be made. **Note: You are responsible for paying your own telephone and cable bills.**

What Happens AFTER I Sign Up For BMC/L.I.F.E. Service?

1. If you need to speak to your Account Manager, call (866) 622-3098.

2. You must have an appointment to meet with your Account Manager. You can schedule an appointment by calling or emailing your Account Manager or speaking with the Front Counter Staff in our office. **Same day appointments will not be scheduled.**

3. Once your budget is set for the month, you must follow the spending plan that is in place for that month. Any requests to change your budget for the following month must be submitted at least 5 days before the last business day of the current month.

4. Personal and Incidental funds are included in your monthly budget. If you have additional funds available after your budgeted expenses are set, you may request to have a portion of those funds issued to you.

   - You must complete an Expenditure Request Form if you are requesting funds in excess of $250.

   - **You must give your Account Manager at least 24 hours to process your request. It is not possible to approve requests immediately.**

   - You are required to submit receipts to show how the funds outside of your set budget are spent.

5. You can receive your personal spending money via check mailed to your address or deposited to the L.I.F.E. Freedom Card (Debit Card). Rent and vendor checks are mailed directly to the person to whom the check is made payable.

6. Checks are mailed the day before their scheduled arrival. For example, if you are scheduled to receive a check on the first of the month, that check will be printed and mailed the afternoon before the first of the month.

7. You can have you utility bills mailed directly to one of the post office boxes possessed by BMC/L.I.F.E. for payment. Your name must be on the bill. **You are responsible for paying your own phone and cable bills.**

8. If you are homeless and do not have a mailing address, we encourage you to obtain a post office box. If you do not have a mailing address, we will recommend that you use the L.I.F.E. Freedom card to receive and use your personal spending money.

9. For your protection, you are the only person that can pick up your check. Vendor checks will not be released to clients. Vendor checks are mailed to the address BMC/L.I.F.E. has on file for that vendor.

10. BMC/L.I.F.E. is always closed the last business day off each month to prepare for the coming month.

11. BMC/L.I.F.E. observes all Federal holidays. If you are scheduled to receive a check on a holiday or a weekend, you should receive your check the day before that holiday.

I understand the above statements and I also understand the following:

1. If you do not receive your check, report it lost or stolen immediately. We will place a stop payment and reissue the check. It takes 45 days from the original check date to reissue another.

2. IT IS VERY IMPORTANT TO NOTIFY YOUR ACCOUNT MANAGER BEFORE THE LAST DAY OF THE MONTH IF YOU ARE PLANNING ON MOVING THE FOLLWING MONTH. IF YOU FAIL TO DO SO, YOUR RENT MIGHT NOT BE PAID CORRECTLY AND YOUR PERSONAL SPENDING CHECK MAY BE MAILED TO THE INCORRECT ADDRESS.

3. You are expected to be a good neighbor and responsible member of your community. We reserve the right to terminate payee services if we receive complaints that you've damaged property, are verbally or physically abusive to neighbors or other members of the community, or are appear to be chronically intoxicated or under the influence of drugs in public. Any funds remaining in your account will be returned to the Social Security Administration.

4. Benefits Management Corporation/Living in Familiar Environments is here to serve you and administer your benefits according to the Social Security Administration regulations. Benefits Management Corp/Living in Familiar Environments will terminate payee services if a client is physically or verbally abusive to BMC/L.I.F.E staff or other clients or damages BMC/L.I.F.E. property. Any funds remaining in your account will be returned to the Social Security Administration. Benefits Management Corporation and Living in Familiar Environments reserves the right to withhold a check or deposit from any client who appears to be intoxicated or under the influence of drugs. This policy is for our client's own protection.

I hereby acknowledge that I understand the Client Agreement and the Benefits Management Corporation (BMC) and Living In Familiar Environments (L.I.F.E.) procedures and received a copy for my records. I agree to abide by the reporting and procedure requirements to maintain my payee service with BMC and L.I.F.E.

______________________________ ______________________________

Client Signature Date

______________________________ ______________________________

BMC / LIFE Staff Member Date

Benefits Management Corporation and
Living in Familiar Environments
P O Box 168045 • Sacramento, CA 95816
P O Box 11012 • San Jose, CA 95103
www.webpayee.com * Phone (866) 622-3098 * Fax (866) 606-3248

Budget Worksheet

Client Name: ______________________________

SSI (T16): _________________________

SSN / TRUST: _____________________________

SSA (T2): _________________________

Effective Date: ____________________________

OTHER: ___________________________

TOTAL: ___________________________

TYPE	AMOUNT	DATE / FREQUENCY	VENDOR NAME & ADDRESS
Rent			
P&I			
Electricity			
GAS			
Other/Misc			
Other/Misc			
Payee Fee			

Total: ___________

Client Signature: ______________________________ Date: ___________

Benefits Management CORPORATION Living In Familiar Environments

LIFE FREEDOM CARD PROGRAM
ACKNOWLEGEMENTS AND AGREEMENT

PLEASE COMPLETE AND RETURN

Acknowledgements. By initialing each item, you acknowledge that you understand each instruction and its importance. **If you do not understand one or more of the instructions, do not initial and contact DCN for further explanation before executing and submitting this Agreement.**

1. Protect your Card and confidential PIN. All Network Transactions made by use of your card will be honored whether authorized by you or not. Notify DCN at once if you believe your Card has been lost or stolen, or that someone has learned your confidential PIN and/or Card Number as instructed throughout this Agreement.

   I acknowledge the importance of protecting my Card information and confidential PIN. Initial _____

2. Avoid using ATMs to reduce the amount of ATM fees and Cardholder Fees you pay. Debit Card Network provides no charge alternatives for balance inquiries and cash withdrawals. If you choose to use ATMs select "Checking Account" only.

   I acknowledge that I can avoid Fees by avoiding ATM use. I also acknowledge that if I choose to use ATMs I should only select "Checking Account." Initial _____

3. If your Card does not work, immediately discontinue its use, as Fees may still apply. If you have entered your PIN incorrectly 3 consecutive times, you may call our 24 hour automated telephone service to reactivate your Card at (866) 78-DEBIT (866-783-3248). For all other reasons, call customer service during our normal business hours at (866) 498-0010.

   I hereby acknowledge that I should immediately discontinue the use of my Card if it does not work when I attempt to use it, as Fees may still apply. Initial _____

4. If you should require a replacement Card, destroy all other Cards at once.

   I hereby acknowledge that I should destroy all Cards except my current Card. Initial _____

5. You agree that any dispute or claim between you and DCN shall be decided by neutral, binding arbitration.

   I hereby acknowledge that I agree to neutral, binding arbitration for any dispute or claim. Initial _____

<table>
<tr><td colspan="2">Cardholder Authorization Signature:</td></tr>
<tr><td colspan="2">Cardholder agrees to review and comply with the Cardholder Account and Card Services Agreement and Disclosure and any accompanying schedules and applications contained herein, and as amended from time to time. This authorization remains in effect until written notice of its revocation is received and authorized by Debit Card Network.</td></tr>
<tr><td colspan="2">By signing below I acknowledge that I have received and read the Cardholder Account and Card Services Agreement and Disclosure, any accompanying schedules and applications and agree to the terms of the Life Freedom Card Program.</td></tr>
<tr><td>Signature of Individual ▶
(Or legal guardian/custodian)</td><td rowspan="2">Date ▶</td></tr>
<tr><td>Print Name:</td></tr>
<tr><td colspan="2">Agency Affiliation: Benefits Management Corporation/LIFE</td></tr>
</table>

Debit Card Network

Affidavit of Individual Identification and Taxpayer Identification Number

PLEASE COMPLETE AND RETURN

Individual Identification			
FIRST NAME:			
LAST NAME:			
MIDDLE NAME:			
PREVIOUS LEGAL NAME (if any):			
DATE OF BIRTH:	MONTH: ____ ____	DAY: ____ ____	YEAR: ____ ____ ____ ____

Part I	Taxpayer Identification Number (TIN)
Enter you TIN in the appropriate box. The TIN provided must match the name given on the "Name" lines. For individuals, this is your social security number (SSN) or employer identification number (EIN).	
Social Security Number or EIN:	____ ____ ____ -- ____ ____ -- ____ ____ ____ ____

Part II Certification

Under penalties of perjury, I certify that:

1. The name above is my correct legal name.
2. The date of birth above is my correct legal date of birth.
3. The 9 digit number above is my correct legal social security number or EIN.
4. To the best of my knowledge I am eligible and capable of accepting and using a prepaid debit card program.

Part III Signature

Signature of Individual ▶ (or legal guardian/custodian)	Date ▶

THIS SPACE INTENTIONALLY LEFT BLANK.

Agency Affiliation

Benefits Management Corporation/LIFE

Schedule A
Debit Card Network

CARDHOLDER FEES

PLEASE READ CAREFULLY AND KEEP FOR YOUR RECORDS

Life Freedom Card
CARDHOLDER FEE SCHEDULE

SERVICE	FEE
Monthly Fee	**No Fee**
Direct Deposit	**No Fee**
Balance Inquiry	**No Fee via Toll Free Automated Telephone Service*** **No Fee via Online Cardholder Account** $0.50 via ATM[1]
POS Purchase U.S. merchant locations only	**No Fee**
Cash-back with POS Purchase	**No Fee**
ATM Cash Withdrawal U.S. ATM locations only	$1.00[1]
Denials	$0.25 POS $0.50 ATM[2]
Email Alerts[3]	**No Fee**
Customer Service Calls	**No Fee**
PIN Change	**No Fee***
Card Replacement	**No Fee**
Monthly Statement Access	**No Fee via Online Cardholder Account**
Monthly Statement Delivery Request Processed by one-time request only, not a recurring service	**No Fee via U.S. Fax** $1.00 via U.S. mail

[1]ATM Owner surcharge fees may apply. See www.lifefreedomcard.com for surcharge-free networks available to you. [2]Withdrawal and balance inquiry from CHECKING account are the only authorized ATM services under the Program. All other ATM service requests will result in a denial and subsequent fee. [3]Email alerts may be selected via our Online Cardholder Account Services available at www.lifefreedomcard.com.

***Automated IVR Telephone Service Call Limits**

A) Balance Inquiry Call Limit	1 per day, plus 10 additional per month; Unused balance inquiry calls will rollover until the last day of each calendar month.
B) PIN Change Call Limit	1 per day

CARDHOLDER ACCOUNT AND CARD SERVICES AGREEMENT AND DISCLOSURE

IMPORTANT

PLEASE READ CAREFULLY AND KEEP FOR YOUR RECORDS

This CARDHOLDER ACCOUNT AND CARD SERVICES AGREEMENT AND DISCLOSURE (this "Agreement") covers your rights, our rights, and the rights of our affiliates and assignees, relating to your election to participate in the Life Freedom Card PIN-Based Prepaid Debit Card Program (the "Program"), and the issuance to you (the "Cardholder"), and your use of, the Life Freedom Card (the "Card"), a PIN-Based Prepaid Debit Card. "You" and "your" means the Cardholder, the person who has received the Card and is authorized to use the Card as provided for in this Agreement. "We," "us," and "our" mean Debit Card Network, LLC ("DCN"), our successors, affiliates and/or assignees. By accepting and using this Card, you agree to be bound by the terms and conditions contained in this Agreement. "Cardholder Account" means an account assigned to you on DCN's Processing System which is accessed by the use of the associated Card. You acknowledge and agree that the Card's value is limited to the disbursements deposited (the "Funds") into your Cardholder Account, and is the value made available to you ("Available Balance") to use for purchases and/or withdrawals, including applicable fees. You acknowledge and agree that your Representative Payee Agency (the "Agency") is solely authorized to deposit Funds into your Cardholder Account on your behalf. The Card will remain the property of DCN and must be surrendered upon demand. The Card is nontransferable, and it may be canceled, repossessed, or revoked at any time without prior notice subject to applicable law. However, anyone who uses the Card, with or without your permission, is bound to the conditions of this entire Agreement. **Keep a copy of your Card Number and the Customer Service Numbers, (866) 78-DEBIT (866-783-3248) (866) 498-0010, in a secure place not with your Card. However, DO NOT write down your CONFIDENTIAL PIN number and never share your confidential PIN with anyone.**

Please read this entire Agreement carefully and keep a copy of it for your future reference.

The USA PATRIOT Act is a federal law that requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. Therefore, DCN will ask for your name, address, date of birth, social security number and other information that will allow us to identify you. DCN may also require you to re-verify your personal information before accessing your account, or when calling to speak to a customer service representative.

The Card is a paperless product, which means DCN will attempt to provide you with notices and communications, including legally required notices and communications through email, mobile messaging and/or through our Online Cardholder Account system accessed on our website www.lifefreedomcard.com. Although the Card is intended to be a paperless program, DCN reserves the right, but not the obligation to communicate with you using all lawful methods of communication including paper and telephone. If you do not wish to comply with these program requirements you are not eligible to participate in the program. (15USC 70001)

By using, or authorizing any other person to use your Card, you hereby understand and agree to the following terms and conditions:

1. **List of Definitions.** Terms (whether initially capitalized or not) defined in other sections of this Agreement shall have the meanings indicated therein. The following terms (whether initially capitalized or not) in this Agreement are defined as follows:

   A. "**DCN**," "**We**," "**us**," and "**our**" means Debit Card Network, LLC, our successors, affiliates and/or representatives.

B. "**Cardholder**," **"you**," and "**your**" means you, as named and signed below, the person who agrees to the terms and conditions of this Agreement and is authorized to use the Card and the associated Cardholder Account as provided for in this Agreement.

C. "**Agreement**" means this entire Agreement, titled "Cardholder Account and Card Services Agreement and Disclosure," and any accompanying schedules and applications.

D. "**Issuer**" means solely Debit Card Network, LLC.

E. "**Agency**" means your Representative Payee Agency, or similar Fiduciary.

F. "**Card**" means the Life Freedom Card, **a PIN-Based Prepaid Debit Card only**, issued by Debit Card Network.

G. "**Cardholder Account**" means an account on DCN's processing system held by a Cardholder.

H. "**Provisional Account**" means a temporary Cardholder Account that has not been funded.

I. "**Funds**" means the disbursements deposited to the Cardholder Account and are accessed by use of an associated Card.

J. "**Card Number**" means the number embossed on the front of your Card, and tied directly to your Cardholder Account.

K. "**PIN**" or "**PIN Number**" means your confidential Personal Identification Number (PIN), a four-digit security code needed to access Funds when using the Card, either assigned randomly by the system, or chosen by you.

L. "**Available Balance**" means the total amount of Funds available to you in your Cardholder Account at any given time.

M. "**Account Records**" means records DCN maintains to account for the value of claims associated with the Card or Cardholder Account.

N. "**Cardholder Fees**" means the Cardholder Fees as set forth in Schedule A of this Agreement.

O. "**Network Transaction**" means one or more of the following as applicable to Card usage, but not limited to:
   i) Any Point-of-Sale purchase or decline (POS);
   ii) Any request using an Automated Teller Machine or decline (ATM);or
   iii) Any other transaction received through the POS or ATM network originated by Card usage.

P. "**Telephone Passcode**" means a confidential four-digit security code, chosen by you and used to access Debit Card Network's 24 hour Automated Telephone Service.

Q. "**Username and Password**" means a confidential unique username associated with a password, both chosen by the Cardholder and used to access Debit Card Network's web based Online Cardholder Account System.

R. "**Program**" means Debit Card Network's PIN-Based Prepaid Debit Card Program as described by this Agreement.

S. "**NACHA**" means the National Automated Clearing House Association.

T. "**ACH Rules**" means the current rules, regulations, operating procedures and guidelines of NACHA.

2. **Cardholder Fees.** The Cardholder agrees to pay DCN the Cardholder Fees as set forth in Schedule A of this Agreement. We reserve the right to amend our Fees from time to time. Fee increases will be posted to your Online Cardholder Account accessible from our website 21 days in advance. At anytime, you may obtain a copy of the current Life Freedom Card Cardholder Fee Schedule by logging into your Online Cardholder Account from our website, www.lifefreedomcard.com.

3. **Provisional Cardholder Account.** A Provisional Cardholder Account will be established once DCN is able to verify all required documentation. Upon establishing a Provisional Cardholder Account, a deposit number will be provided to your Agency. Debit Card Network reserves the right to cancel any Provisional Cardholder Account that has not been funded by your Agency within 60 days.

4. **Cardholder Account Activation.** Your Agency will transmit a zero-dollar transaction, known as an ACH Pre-notification, in your name to activate your Cardholder Account.

5. **Initial Card.** Your initial Card will be produced and mailed once your Cardholder account has been activated.

6. **Cardholder Account.** Once activated, you be assigned an unique individual Cardholder Account on Debit Card Network's Processing System. While this is not an individual checking account, it will function as such when you are making transactions with your Card. Particularly when accessing your Cardholder Account through an ATM (i.e. select "checking" or "checking account" ONLY when accessing your account through an ATM).

7. **Access to Funds via the Card.** The originator of Funds, your Agency, will deposit Funds due you into your Cardholder Account maintained on DCN's Processing System. In turn, you can access your Funds by use of the Card.

8. **Availability of Funds.** Your deposited Funds will be available, as required by NACHA rules, on the **effective date** of the transfer, designated by your Agency. Use your Card only to the extent that you have available Funds (the "Available Balance"). You may use DCN's automated web and/or telephone service as provided below to access your current Available Balance. (Available Balance does not mean total Funds). Denial fees can occur if you use your Card and do not have sufficient funds.

9. **Services.** The following services ("Cardholder Services") are available to Cardholders, but not limited to:
   A. **24-hour Automated Telephone Service:**
      i) Call **(866) 78-DEBIT (866-783-3248)** to access the following, but not limited to:
         a. Obtain your current Available Balance;
         b. Change your Telephone Passcode;
         c. Change your Card's Personal Identification Number (PIN); and
         d. Report a lost or stolen Card.
      ii) Login to your Online Cardholder Account at **www.lifefreedomcard.com** to access the following, but not limited to:
         a. Obtain your current Available Balance;
         b. Retrieve your Transaction history;
         c. Update your Cardholder Account Profile;
         d. Change your Telephone Passcode;
         e. Set up Email notifications on your Cardholder Account;
         f. Report a lost or stolen card; and
         g. Retrieve Notices about your Cardholder Account and Services.
   B. **Merchant Services and Cash Back.** You may use your Card to purchase goods and services at any Point of Sale (POS) retailer or other establishment displaying the network logo(s) that appear on the back of your Card. You may also request cash back when making a POS purchase.
   C. **Automated Teller Machine ("ATM") Services**. You may use your Card at any ATM that bears the network logo(s) that appear on the back of your Card. By selecting "Checking Account", you may withdraw cash or check your Available Balance. ATM Owners may charge ATM Surcharge fees. Check our website at www.lifefreedomcard.com for available ATM Surcharge-free networks available to you.
   D. **Avoiding ATM Fees.** To avoid ATM fees, receive cash back when making POS purchases and check your Available Balance using our 24-Hour Automated Customer Service. Also, check our website at www.lifefreedomcard.com for available ATM Surcharge-free networks available to you.

10. **Services Not Available.** The following services are not available through this Program:
    A. **No Interest or Credit Available.** This Cardholder Account is not an interest bearing account. No credit is available through this Program;
    B. **Signature Services.** Signature transactions are not permitted with this Card;
    C. **Overdraft Protection and Associated Fees.** You have no overdraft protection with this Card and no associated fees; and
    D. **Secondary Cardholder.** Secondary cards for additional cardholders are not permitted. Should you give your Card and/or confidential PIN information to another person, you hereby acknowledge that you have authorized such person(s) to use your Card and access all of your Funds, without limit. You will be liable for all their use of the Card. **Notify DCN AT ONCE if you believe your Card has been lost or stolen, or that someone has learned your confidential PIN and/or Card Number. The best way of minimizing your possible losses is to use our 24 hour automated telephone service at (866) 78-DEBIT (866-783-3248), or log into your Online Cardholder Account at www.lifefreedomcard.com to report your card lost or stolen. If you need to speak to a representative, you may call customer service during our normal business hours at (866) 498-0010 (see section below, 32. Business Days and Hours).**

PERSONAL IDENTIFICATION NUMBER ("PIN") NOTICE

THIS AGREEMENT CONTAINS A PERSONAL IDENTIFICATION NUMBER ("PIN") CLAUSE. PLEASE READ THIS PROVISION CAREFULLY, AS IT AFFECTS YOUR LEGAL RIGHTS OF YOUR FUNDS.

11. **Personal Identification Number ("PIN").** Your PIN is a confidential 4-digit security number. DCN will either: (1) Assign you a system generated confidential PIN, or (2) You will choose your own confidential PIN, which will enable you to identify you as the authorized Cardholder when using your Card. Your PIN is a security feature that functions as your signature to identify you as the legal user of the Card, and authorizes any Network Transactions you make using your Card. Heavily guard your PIN at all times. You must not reveal your PIN to anyone. You agree to partner with Debit Card Network, the Issuer of the Card, by adhering to the Program's PIN safeguarding requirements. These requirements are in place to protect the Funds in your Cardholder Account. You assume full responsibility for any and all Network Transactions made with the Card by authorized and unauthorized users. You are liable for all transactions made with your Card. Know that if you chose to give your Card and/or PIN to another person, you have authorized such person(s) to use your Card and access your Funds, without limit, and you will be liable for all their use of the Card. You could lose all of the funds in your Cardholder Account. **Notify DCN AT ONCE if you believe your Card has been lost or stolen, or that someone has learned your confidential PIN and/or Card Number. The best way of minimizing your possible losses is to use our 24 hour automated telephone service at (866) 78-DEBIT (866-783-3248), or log into your Online Cardholder Account at www.lifefreedomcard.com to report your card lost or stolen. If you need to speak to a representative, you may call customer service during our normal business hours at (866) 498-0010 (see section below, 32. Business Days and Hours).**

12. **Card Disabled Due to Incorrect PIN.** Your Card will be disabled if the PIN is entered incorrectly three consecutive times while attempting to authorize a POS or ATM Transaction in order to protect the Funds in your Cardholder Account. If you made a mistake and know your correct PIN, you may reactivate your card by calling our 24 hour automated phone system at (866) 78-DEBIT (866-783-3248).

13. **Receipts at Electronic Terminals.** You can get a receipt at the time you use your Card at a Point of Purchase retail location to purchase goods or services through a merchant at retail or other establishment, or when using an ATM.

14. **Periodic Account Statements.** You may obtain electronic monthly statements by logging into your Online Cardholder account through our website, www.lifefreedomcard.com. You may receive the following information electronically when logging into your Cardholder Account online:
    A. Available balance;
    B. Daily Network Transaction and Cardholder Fee activity and history;
    C. Monthly statements:
        i) Download and save to your PC,
        ii) Download and print from your PC;
    D. Elect to participate in Email Alerts;

E. Amendments to this Agreement, including, without limitation, any changes set forth thereon, or any other terms and conditions of your use of the Card; and
F. All other disclosures, notifications and information relating to the Card and the terms of your use of the Card.

If you are unable to print a statement from our website, you may request a written statement be faxed or mailed to you to by calling (866) 498-0010, fees may apply.

15. **Unpaid Cardholder Fees.** Debit Card Network will post all Cardholder Fees to your Cardholder Account. You agree: (1) DCN may take the amount of unpaid Fee(s) from subsequent deposits to your Cardholder Account, or (2) You will pay DCN, upon demand, the amount of the unpaid Fee(s). (3) You will pay any unpaid Fees prior to closing your Cardholder Account. Debit Card Network does not impose interest or penalties on unpaid Fees.

16. **Negative Balances.** The amount available on your Card will be reduced by the amount of your Network Transactions, plus applicable Cardholder Fees. Network Transactions that will create a negative balance in your Cardholder Account are not permitted, but can occur in limited circumstances. If a negative balance does occur in your Cardholder Account, you agree: (1) DCN may take the amount of the negative balance from subsequent deposits to your Cardholder Account, or (2) You will pay DCN, upon demand, the amount of the uncollected fee. (3) You will pay any unpaid negative balances prior to closing your Cardholder Account. Debit Card Network does not impose additional overdraft fees.

17. **Limitations of the Cardholder Account and/or Card.** The following limitations apply to your Cardholder Account and/or Card:
    A. The minimum single deposit to the Account is $1.00;
    B. The maximum deposit to the Account is $2,500.00 during any business day (deposits made after 2:01 pm on Friday will be added to Monday's business day);
    C. Your ATM withdrawals cannot exceed $300.00 during any 24-hour period; and
    D. Your Point of Sale (POS) purchases cannot exceed $2,500.00 during any 24-hour period.
    E. You may be denied the use of the Card if:
       i) You exceed the daily ATM and/or POS limits;
       ii) You do not have adequate funds in your Cardholder Account;
       iii) You do not enter the correct PIN on the third consecutive attempt;
       iv) The Card has been damaged;
       v) You use the Card, or Cardholder Account in contradiction to this Agreement or applicable laws; and
       vi) To protect your Funds as determined by Debit Card Network.
    F. Do not use, or allow others to use an expired, revoked, cancelled, suspended, or otherwise invalid Card, as Cardholder Fees may apply.

18. **Error Resolution.** In Case of Errors or Questions About your Cardholder Account, Telephone us at (866) 498-0010, Write to us at 2640 Cordova Lane, Rancho Cordova, CA 95670, or Email us at info@lifefreedomcard.com as soon as you can, if you think your statement or receipt is wrong, or if you need more information about a transfer listed on the statement or receipt. If you are unable to print a statement from our website, you may request a written statement be faxed or mailed to you to by calling (866) 498-0010 (fees may apply). DCN must be notified by you no later than 60 days after DCN made available via the Web, or mailed a written statement at your request, the FIRST statement on which the problem or error appeared, or from the date you FIRST accessed the Network Transaction and Cardholder Fee history screen via the Web, on which the problem or error appeared, whichever is earliest. When notifying DCN of possible ERROR, please be prepared to:
    A. Give your name and Card Number and any other identifying information we may request;
    B. Describe the error or Network Transaction in question, and reason you believe there is an error or you need more information; and
    C. Give the dollar amount of the suspected error and where and when the Network Transaction took place. If you tell us verbally, we may require that you send us your complaint or question in writing within ten (10) business days.
    D. Within ten (10) business days of reporting the suspected error, we will determine whether or not there had been a mistake. If an error has occurred, we will correct the error promptly. If additional time is required for research, we may take up to forty-five (45) days to investigate your complaint or question. If we decide to do this, we will correct your Cardholder Account within ten (10) business days for the amount you think is in error, so that you will have the use of the money during the time it takes us to complete our investigation.

This type of credit is referred to as a "provisional" credit. If we determine there was no error, we will reverse this credit. If we ask you to put your complaint or question in writing and we do not receive it within ten (10) business days, we may not credit your Cardholder Account.

E. For errors involving new Cardholder Accounts, Point of Sale, or foreign-initiated transactions, we may take up to 90 days to investigate your complaint or question. For new Cardholder Accounts, we may take up to 20 business days to credit your Cardholder Account for the amount you think is in error.

F. We will tell you the results within three (3) business days after completing our investigation. If we decide that there was no error, we will send you a written explanation. You may request, in writing, copies of the documents that we used to complete our investigation.

19. **Your Liability for Unauthorized Network Transactions.** You assume full responsibility for any and all Network Transactions made with the Card by authorized and unauthorized users. You are liable for all Network Transactions made with your Card. Know that if you chose to give your Card and/or PIN to another person, you have authorized such person(s) to use your Card and access your Funds, without limit, and you will be liable for all their use of the Card. You could lose all of the Funds in your Cardholder Account. **Notify DCN AT ONCE if you believe that your Card has been lost or stolen, or that someone has learned your confidential PIN and/or Card Number. The best way of minimizing your possible losses is to use our 24 hour automated telephone service at (866) 78-DEBIT (866-783-3248), or log into your Online Cardholder Account at www.lifefreedomcard.com to report your card lost or stolen. If you need to speak to a representative, you may call customer service during our normal business hours at (866) 498-0010 (see section below, 32. Business Days and Hours).**

20. **Our Liability for Failure to Complete Network Transactions.** If DCN does not properly complete a Network Transaction for you on time and in the correct amount, DCN may be liable for your losses. Below are exceptions. DCN will not be liable, but not limited to:

A. If, through no fault of DCN, you do not have sufficient Funds available in your Account to complete the Network Transaction;

B. If an ATM where you are making a withdrawal does not have enough cash;

C. If an electronic terminal where you are making a Network Transaction does not operate properly, and you knew about the problem when you initiated the Network Transaction;

D. If a merchant refuses to accept your Card;

E. If circumstances beyond our control (such as fire, flood or communications or computer failure) prevent the completion of the Network Transaction, despite our reasonable efforts;

F. If the Card has been reported as lost or stolen or has been suspended by us, if we have limited or revoked your Card privileges or if we have reason to believe the Transaction is not authorized by you;

G. If there is a hold on your Cardholder Account for any reason;

H. If your Funds are subject to legal process or other encumbrance restricting their transfer;

I. If your funding eligibility terminates by your Agency's request; or

J. If your authorization terminates by operation of law.

21. **Bank Liability.** This Agreement is between you (the "Cardholder"), and DCN (the "Issuer"), and for no reason shall Five Star Bank (the "Bank"), DCN's chosen financial institution, their successor or affiliates be subject to any lawsuits or claims. All questions about Funds, or Network Transactions made with your Card, must be directed to us, DCN, and not to the Bank. DCN is responsible for the debit card Program and encompassing service, and resolving any claims, errors, or concerns regarding your Card.

22. **Contact Information Maintenance.** Important: For the protection of your Funds DCN requires that you keep all personal information current and notify us of any changes.

A. While you are participating in this Program, you must be able to be reached by at least 2 of the following methods:

i) Telephone;

ii) Cell phone;

iii) Text messaging;

iv) Email address;

v) Mailing address as defined:

a. Residential, PO Box, or other legal address that you are authorized to receive direct mail;

b. C/O address that you are authorized to receive mail;

c. General Delivery, in your name, to a zip code specified by you; or

vi) Other reasonable method approved by DCN and your Agency.

B. If we are unable to reach you with the methods you provide us, at DCN's discretion, we may disable your Card to protect your Funds. Call DCN AT ONCE if you would like to reactivate your Card at (866) 498-0010. If we do not hear from you, we reserve the right to follow the Dormant Cardholder Account procedures as explained in the next section below.

23. **Notification of Misuse of Card or Cardholder Account.** DCN will notify you and your Agency if we detect misuse of your Card or Cardholder Account. You agree to comply with all reasonable requests from DCN or your Agency to resolve the detected misuse.

24. **Dormant Cardholder Account; Return of Funds.** For the protection of your Funds, unless you notify DCN of special circumstances, after 30 days of inactivity DCN shall: (1) consider your Cardholder Account to be dormant, and (2) disable your Card, if not previously disabled. If your Card is not functioning and you believe that it may be disabled from inactivity or other reason, and you would like to reactivate your Card call DCN at (866) 498-0010. After 30 days of inactivity, DCN will work with your Agency to make all reasonable efforts to contact you. If you have not contacted DCN, or if we or your Agency are unable to contact you within 45 days of inactivity on your Cardholder Account, you agree that your Cardholder Account will be closed and your Funds will be returned to your Agency. Calling our 24-hour automated phone service, or logging into our Online Cardholder Account Service through our website qualifies as Cardholder Account activity. The following actions do not quality as Cardholder Account activity: Speaking to, leaving a voice message, emailing, or submitting a contact us web form to a DCN customer service representative, or contacting your Agency.

25. **Self-Cardholder Account Closure.** If you no longer wish to participate in the Program, you must contact your Agency, as sole funding source, to close your Cardholder Account. You must notify your Agency and request they stop funding your Cardholder Account on your behalf. You are still responsible for all Network Transactions and associated Cardholder Fees that are generated from the use of your Card. **You may elect to notify DCN or your Agency to keep the Card and Cardholder Account active if you have a positive Available Balance**.

A. **General Closure Request.** After all Network Transactions and associated Cardholder Fees have been processed, DCN will:
   - i) If there are no available Funds, close the Card and Cardholder Account; or
   - ii) If there is a positive Available Balance and:
     - a. 1) Your Card is active and 2) you notified the Agency or Debit Card Network in advance to keep the Cardholder Account open and active, you will have 30 days to use the Card to access your Funds. After 30 days DCN shall return remaining Funds to the you through your Agency; or
     - b. 1) Your Card is not active, and/or 2) you have not notified the Agency or Debit Card Network in advance to keep your Cardholder Account open and active, your Cardholder Account and Card will be closed and DCN shall return remaining Funds to you through your Agency.
   - iii) If you have outstanding invoiced fees, DCN will notify you and your Agency of the amount to pay before your Cardholder Account can be closed; or
   - iv) In limited circumstances, if you have a negative Available Balance, DCN will notify you and your Agency of the amount of the negative balance to pay before your Cardholder Account can be closed.
   - v) For the purpose of this Agreement, Cardholder Funds returned to the Agency are returned to the Cardholder.
   - vi) You will have access to your closed Cardholder Account through our Online Cardholder Account system accessed through our website www.lifefreedomcard.com for a minimum of two years.

26. **Agency Stop Funding and Subsequent Closure.** To be eligible to participate in the program, your Agency must continue to fund your Cardholder Account. Should your Agency stop funding your Cardholder Account for any reason you will become ineligible to participate. You are still responsible for all Network Transactions and associated Cardholder Fees that are generated from the use of your card. After all Network Transactions and associated Cardholder Fees have been processed, DCN will:

A. **Agency Closure Request.** After all Network Transactions and associated Cardholder Fees have been processed, DCN will:
   - i) If there are no available Funds, close the Card and Cardholder Account; or
   - ii) If there is a positive Available Balance, close the Card and Cardholder Account and return remaining Funds to the you through your Agency; or

iii) If you have outstanding invoiced fees, close the Card and notify you and your Agency of the amount to pay before your Cardholder Account can be closed; or
iv) In limited circumstances, if you have a negative Available Balance, close the Card and notify you and your Agency of the amount of the negative balance to pay before your Cardholder Account can be closed.
v) For the purpose of this Agreement, Cardholder Funds returned to the Agency are returned to the Cardholder.
vi) You will have access to your closed Cardholder Account through our Online Cardholder Account system accessed through our website www.lifefreedomcard.com for a minimum of two years.

27. **Agency Request to Return Funds.** Your Agency, upon furnishing a reclamation notice or similar notice, in your name from a government or similar agency, may request in writing that Funds be returned to them on your behalf. DCN will only do so only after all Network Transactions and associated fees have been processed. Your Card may be temporarily disabled while we process the return request.

28. **Escheatable Funds. Any Funds remaining in an Account subject to State Escheatable Funds regulations shall be handled as required by law.**

29. **Record Retention for Closed Cardholder Accounts.** Debit Card Network maintains Cardholder information for 5 years after the closure of a Cardholder Account, unless otherwise required by law.

30. **Debt Payments.** Debit Card Network is not responsible in any dispute regarding any legitimate payment on behalf of a Cardholder.

31. **FDIC Insurance.** The actual Funds ("Deposits") in your Cardholder Account will be held in a custodial account at the Bank on your behalf. The custodial account Funds ("Deposits") are insured to the maximum limit provided by the FDIC. This type of FDIC insurance is known as "pass-through" insurance. This in no way means that you hold an individual bank account.

32. **Confidentiality.** Your personal information is confidential and private. DCN does not share your personal information with third parties. However, it may be necessary to disclose information to third parties as it relates to Network Transaction history:
    A. Where it is necessary for completing transactions;
    B. In order to verify the existence and conditions of your Card and Funds for a third party, such as a credit bureau or merchant;
    C. In order to comply with government agency or court orders, or other legal reporting requirements;
    D. If you give DCN your written permission; or
    E. If Debit Card Network, its Affiliates, or other Agency suspects that the Card was obtained fraudulently, or suspects that a Card has been used fraudulently.

33. **Amendments and Notification.** DCN may change or add additional terms to this Agreement at any time, with or without cause, and without giving you notice, subject to applicable laws. DCN reserves the right to make available to you any notice of changes to existing terms, or the addition of new terms electronically through our Online Cardholder Account system accessed through our website, www.lifefreedomcard.com. DCN also reserves the right if you have provided us the means to deliver notification by email, or by mobile message of such changes posted to your Online Cardholder Account at www.lifefreedomcard.com.

34. **Business Days and Hours.** DCN business days and hours are Monday through Friday, 8:00 am–5:00 pm, Pacific Time. DCN is closed on state and federal banking holidays.

35. **Severability.** In the event that any provision of this Agreement is determined to be invalid, illegal or unenforceable, such determination shall not affect the other provisions of this Agreement.

36. **Hold harmless.** Cardholder agrees to hold harmless and shall defend and indemnify DCN from any and all actual or alleged claims, demands, causes of action, liability, loss, damage and/or injury (to property or persons) whether brought by individual or other entity, or imposed by a court of law or by administrative action in any Federal, State, or local government body or agency, arising out of or incident to any acts, omissions, negligence, or willful misconduct by the Cardholder or Cardholder's agents, representatives, or volunteers in connection

with or arising out of the use of the Card. This indemnification and hold harmless applies to and includes, without limitation, the payment of all penalties, fines, judgments, awards, decrees, attorney's fees or related costs or expenses, and any reimbursement to DCN for all legal expenses and costs incurred by it.

37. **Separate entity.** Cardholder agrees and acknowledges that DCN is a separate and distinct entity and in no way or manner is related to BENEFTITS MANAGEMENT CORPORATION/LIFE, a Non-Profit Corporation, and that DCN is not responsible for the actions, statements, or other activities of BENEFTITS MANAGEMENT CORPORATION/LIFE, a Non-Profit Corporation as it relates to the use and/or maintenance of the Card issued to Cardholder. Further, Cardholder agrees and acknowledges that no action can be brought against DCN for the actions, statements or other activities of BENEFTITS MANAGEMENT CORPORATION/LIFE, a Non-Profit Corporation or its personnel, employees, agents, contractors or volunteers.

ARBITRATION NOTICE

THIS AGREEMENT CONTAINS AN ARBITRATION CLAUSE. PLEASE READ THIS PROVISION CAREFULLY, AS IT AFFECTS YOUR LEGAL RIGHTS. IT PROVIDES THAT ANY CLAIM RELATING TO YOUR CARDHOLDER ACCOUNT, THE CARD, OR RELATED SERVICES, SHALL BE RESOLVED BY BINDING ARBITRATION. YOU ARE ENTITLED TO A FAIR HEARING, BUT THE ARBITRATION PROCEDURES ARE SIMPLER AND MORE LIMITED THAN RULES APPLICABLE IN COURT, AND ARBITRATION DECISIONS ARE SUBJECT TO VERY LIMITED REVIEW.

38. **Arbitration.** Any dispute or claim between you, the Cardholder, and us, DCN, shall be decided by neutral, binding arbitration. The arbitrator shall be a retired judge or justice, or an attorney with at least 5 years of business and commercial law experience, unless parties mutually agree to a different arbitrator, who shall render an award in accordance with substantive California law. The parties shall have the right to conduct discovery in accordance with California code of Civil Procedure 1283.05. In all other respects, the arbitration shall be conducted in accordance with Title 9 of Part III of the California Code of Civil Procedure. Judgment on any such arbitration award may be entered in any court having proper jurisdiction. This Agreement and any addendums, schedules or applications shall be governed and construed in accordance with the laws of the State of California. No potential arbitrator may serve as an arbitrator unless he or she has agreed in writing to abide by and be bound by these procedures. The arbitrator may not award non-monetary or equitable relief of any sort. **The designated arbitrator shall have no power to award (i) damages inconsistent with this Agreement or (ii) punitive damages or any other damages not measured by the prevailing party's actual damages, and parties expressly waive their right to obtain such damages in arbitration or in any other forum.** In no event, even if any other portion of these provisions is held to be invalid or unenforceable, shall the arbitrator have the power to make an award or impose a remedy that could not be made or imposed by a court deciding the matter in the same jurisdiction. All arbitration proceedings shall take place in Sacramento County, California.