



Disability Foundation, Inc. Third Party Pooled Flexible Spending Trust
Account Agreement

This is an application by the Grantor(s) listed below to establish an Account to be administered in accordance with the terms and conditions of the Disability Foundation, Inc. Third Party Pooled Flexible Spending Trust Agreement (“Trust”), Ohio Revised Code Section 5163.21(G), and the Collective Investment Fund Law, 12 C.F.R. Section 9.18, as may be amended. The Account so established will be administered in accordance with the terms of the Trust, as amended from time to time, and any amendments or restatements shall be retroactively applicable to all Account Agreements related to the Trust. In the event there is a conflict between the terms of the Trust and the Account Agreement, the terms of the Trust shall govern. *The assets deposited and held in this Account have never belonged to the Individual with Disabilities nor shall the assets be deemed available to the Individual with Disabilities.*

- 1. **INVESTMENT TRUSTEE:** KEY BANK, N.A.
- 2. **DISTRIBUTION TRUSTEE:** THE DISABILITY FOUNDATION, INC.
- 3. **GRANTOR(S):**

Name of First Grantor: _____
Address: _____
City, State, Zip: _____
Telephone(s): _____
Email: _____
Social Security Number: _____
Relationship to Individual with Disabilities: _____

Name of Second Grantor: _____
Address: _____
City, State, Zip: _____
Telephone(s): _____
Email: _____
Social Security Number: _____
Relationship to Individual with Disabilities: _____

4. INDIVIDUAL WITH DISABILITIES (the BENEFICIARY):

Name: _____
Address: _____
City, State, Zip: _____
Telephone(s): _____
Email: _____
Date of Birth: _____
Social Security Number: _____

You must complete a Beneficiary Profile with information regarding this Individual with Disabilities. It is the duty of the Personal Representative to regularly review the Beneficiary Profile, and promptly notify the Disability Foundation, Inc. of any changes as they occur.

5. PERSONAL REPRESENTATIVE:

The Personal Representative is responsible for providing information and updates about the Individual with Disabilities. The Personal Representative is also responsible for asking the Trust to expend funds for the Individual with Disabilities, and providing supporting information.

INITIAL PERSONAL REPRESENTATIVE

Name: _____
Address: _____
City, State, Zip: _____
Telephone(s): _____
Email: _____
Relationship to Individual with Disabilities: _____

In case the Personal Representative named above is unable or unwilling to serve or to continue to serve in that capacity, the Grantor(s) names the following **Successor Personal Representatives** to serve (in the order listed):

Name: _____
Address: _____
City, State, Zip: _____
Telephone(s): _____
Email: _____
Relationship to Individual with Disabilities: _____

Name: _____
 Address: _____
 City, State, Zip: _____
 Telephone: _____
 Cell/Mobile: _____
 Email: _____
 Relationship to Individual with Disabilities: _____

6. DISTRIBUTIONS FOR THE INDIVIDUAL WITH DISABILITIES:

Income and principal shall be distributed by the Distribution Trustee in cash or in kind, at the direction of the Distribution Trustee, for the benefit of the Individual with Disabilities during his or her lifetime or until the termination of the Account, whichever occurs sooner.

7. USE OF FUNDS AFTER THE DEATH OF THE INDIVIDUAL WITH DISABILITIES:

Upon the death of the Individual with Disabilities, the Grantor(s) acknowledge and agree that **ten percent (10%)** of any funds remaining in the Account will be retained by the Disability Foundation, Inc., to be used for the funding of Disability Programs and Services. The Grantor(s) direct that the remaining funds in the Account, beyond the amount retained by the Disability Foundation, Inc., shall be distributed as follows, in the order listed (*please check all that apply*):

_____ Individual with Disabilities' funeral and interment expenses

_____ Attorney fees and expenses related to the administration of the estate of the Individual with Disabilities

*(The Personal Representative or other representative of the estate of the Individual with Disabilities must notify the Disability Foundation, Inc. in writing within **90 days** after the death of the Individual with Disabilities that attorney fees and expenses of administration will be claimed. If no such notice is received within 90 days, then the Disability Foundation will eliminate this category and distribute the funds to the next listed category.)*

_____ To the following remainder beneficiaries:

(Please complete the primary and secondary beneficiary charts on the following page, and please attach additional pages if more space is required.)

PRIMARY REMAINDER BENEFICIARIES:

Full Name	Relationship to Individual with Disabilities	Current Address	Percentage <i>(should add up to 100%)</i>	If Deceased... <i>(complete this if the beneficiary is a person)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to Secondary Beneficiary list)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to Secondary Beneficiary list)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to Secondary Beneficiary list)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to Secondary Beneficiary list)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to Secondary Beneficiary list)</i>
The Disability Foundation, Inc.	Charitable Organization	1401 S. Main Street Dayton, OH 45409	_____ %	

SECONDARY REMAINDER BENEFICIARIES:

Full Name	Relationship to Individual with Disabilities	Current Address	Percentage <i>(should add up to 100%)</i>	If Deceased... <i>(complete this if the beneficiary is a person)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to the Disability Foundation, Inc.)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to the Disability Foundation, Inc.)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to the Disability Foundation, Inc.)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to the Disability Foundation, Inc.)</i>
			_____ %	<input type="checkbox"/> Per Stirpes <i>(goes to this person's descendants)</i> <input type="checkbox"/> Lapse <i>(goes to the Disability Foundation, Inc.)</i>
The Disability Foundation, Inc.	Charitable Organization	1401 S. Main Street Dayton, OH 45409	_____ %	

8. IRREVOCABILITY OF THE TRUST: (please select only **one** option)

- _____ The Account *cannot* be revoked. It is irrevocable.
- _____ The Account *can* be revoked by *any* Grantor. It becomes irrevocable at the death of the *last* Grantor.
- _____ The Account *can* be revoked by *unanimous* agreement of *all* living Grantors. It becomes irrevocable at the death of the *first* Grantor.

9. PROPERTY TRANSFERRED BY THE GRANTOR(S):

How will the Account be funded (please check all that apply)?

- _____ Check (to be funded during either Grantor's lifetime)
- _____ Specific Bequest through a Last Will and Testament
- _____ Specific Bequest through a Trust
- _____ Payable on death beneficiary designation on financial account(s)
- _____ At Grantor's death (if only one Grantor)
- _____ At the last Grantor's death (if more than one Grantor)
- _____ Life Insurance proceeds
- _____ Other (please describe): _____
- _____
- _____

No assets that have ever been owned by the Individual with Disabilities can ever be added to this Account. By signing this Account Agreement, the Grantor(s) certify that the assets to be contributed to this Account meet this requirement.

10. FEES:

Fees are based on a published fee schedule maintained by the Distribution Trustee. The Distribution Trustee and Investment Trustee reserve the right to modify the fee schedule from time to time, in their discretion.

11. APPLICATION:

Grantor(s), who is eighteen years of age or older and of sound mind, hereby applies to establish an Account in the Disability Foundation, Inc. Third Party Pooled Flexible Spending Trust Agreement. Grantor(s) understands the terms of the Disability Foundation, Inc. Third Party Pooled Flexible Spending Trust Agreement and of this Account Agreement, ratifies and adopts said Agreements, and agrees to be bound by the terms of said Agreements.

Grantor(s) agrees to provide all information necessary to establish this Account, and to update such information on an ongoing basis, so that the Distribution Trustee and Investment Trustee may meet their respective requirements under federal and state law, as well as under all internal policies of each organization. Grantor(s) acknowledge and accept that neither the

Distribution Trustee nor the Investment Trustee can guarantee the Individual with Disabilities will receive or continue to receive any governmental benefits.

Date

Signature of First Grantor

Date

Signature of Second Grantor

12. APPROVAL:

The application to establish this Account with the Trust is hereby approved.

THE DISABILITY FOUNDATION, INC.

Date

By: _____

Its: _____