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. <u>INDIVIDUAL WITH DISABILITIES (the BENEFICIARY)</u>:

Name: _____

Address: _____

City, State, Zip: _____

Telephone(s): _____

Email: _____

Date of Birth: _____

Social Security Number: _____

You <u>must</u> 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. <u>PERSONAL REPRESENTATIVE</u>:

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. <u>DISTRIBTIONS FOR THE INDIVIDUAL WITH DISABILITES</u>:

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. <u>USE OF FUNDS AFTER THE DEATH OF THE INDIVIDUAL WITH DISABILITIES</u>:

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 <u>all</u> 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 <u>must</u> 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 *(should add up to 100%)*	If Deceased… *(complete this if the beneficiary is a person)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to Secondary Beneficiary list)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to Secondary Beneficiary list)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to Secondary Beneficiary list)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to Secondary Beneficiary list)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to Secondary Beneficiary list)*
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 *(should add up to 100%)*	If Deceased… *(complete this if the beneficiary is a person)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to the Disability Foundation, Inc.)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to the Disability Foundation, Inc.)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to the Disability Foundation, Inc.)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to the Disability Foundation, Inc.)*
			________%	☐ **Per Stirpes** *(goes to this person's descendants)* ☐ **Lapse** *(goes to the Disability Foundation, Inc.)*
The Disability Foundation, Inc.	Charitable Organization	1401 S. Main Street Dayton, OH 45409	________%	

8. <u>IRREVOCABILITY OF THE TRUST</u>: (*please select only **<u>one</u>** 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. <u>PROPERTY TRANSFERRED BY THE GRANTOR(S)</u>:

How will the Account be funded (*please check <u>all</u> 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*): _____

_____

_____

<u>No</u> 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. <u>FEES</u>:

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. <u>APPLICATION</u>:

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. ***NOTE:*** *(this agreement must be signed before 2 witnesses or a notary, unless signed in our office)*

_____	_____
Date	Signature of First Grantor
_____	_____
Date	Signature of Second Grantor
_____	_____
Printed Name of Witness	Signature of Witness
_____	_____
Printed Name of Witness	Signature of Witness

OR

State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned notary public, personally appeared _____, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary

12. <u>APPROVAL</u>:

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

<u>THE DISABILITY FOUNDATION, INC.</u>

_____ By: _____
Date

Its: _____