HEALTH CARE REIMBURSEMENT PLAN ENROLLMENT FORM

EMPLOYER NAME____

EMPLOYER GROUP____

Participant ____SS #______________________

Street____

City, State Zip Code____

Date of Birth ______________Home#(   )______________Work#(   )____________________

EMPLOYER CONTRIBUTION

Employer authorizes the sum of $__________to be contributed to the____________________ __________________________Health Reimbursement Arrangement plan, North Shore Bank Account #___________________as per Plan Document 7.4 Establishment of Account; Trust Agreement Article II, A. Investment of Assets; Article II Participant Directed Fund A. (1.)(2.)(3.).

Employer further authorizes North Shore Bank to accept, from Participant, direction and/or future reallocation of investment options under this plan.

DEPENDENTS

Spouse____DOB__________

Legal Dependent____DOB__________

____DOB__________

____DOB__________

PARTICIPANT(Signature)_______________________________ Date______________
(I certify that the above named persons qualify as legal dependents)

PLAN ADMINISTRATOR

(Signature)____Date______________

Print Name/Title____

Please mail to:

North Shore Bank
Attn: Retirement Services
15700 W Bluemound Road
Brookfield WI 53005