HUDSON COUNTY COMMUNITY COLLEGE
HUMAN RESOURCES

HCCC Benefits for Full Time Employees

At HCCC, we value and appreciate all of our employees. We acknowledge the importance of providing a comprehensive benefits package. Below is a brief glance of the HCCC benefits, perks, and discounts offered.

***Full Time Benefits are effective after 60 days of Employment**

Medical Benefits

NJ Educators Health Plan – Horizon BCBSNJ

- PPO Plan
- Cost determined by percentage of base salary (Affordable Health Insurance)
    - Active Employees: Calculate your estimated premium contribution, visit *HorizonBlue.com/shbpcalculator*.
- Health Waiver Option – Stipend Program **If Applicable*

Delta Dental NJ

- Delta Dental PPO Plus Premier Plan
- **No cost to employee (Employer covers full cost, including family coverage)**

National Vision Administrators, L.L.C.

- www.e-nva.com
- **No cost to employee (Employer covers employee coverage only) cost for additional dependents, family coverage.**

Retirement Plans

PERS – Public Employee Retirement System (Full Time Staff)

- Pension through New Jersey Division of Pensions & Benefits (NJDPB)
- Pension Plan with payment options upon retirement.
- Vested after 10 years of service

NJ Alternative Benefit Plan (ABP) Retirement

- ABP is a tax-sheltered, defined contribution retirement program for higher education *faculty and certain administrators*.
- Choice between seven carriers; TIAA, AIG, AXA(Equitable), VOYA, Metlife, MassMutual & Prudential
- Mandatory 5% contribution with an 8% Employer match.
- Member becomes vested after one year of employment.

Voluntary 403b or 457b Plan Options

- Option to contribute more than the Mandatory 5% contribution rate.
- Choice of six carriers
- Option to choose percentage of dollar amount towards contribution.

Employee Leave Faculty

Full Time Accrued Time

- Personal = 21 hours per fiscal year * Does not rollover (1st year: Prorated based on start date)
- Sick = 4.38hrs every pay period *Up to 15 days per year (Does not expire)

Additional Benefits Plus Perks

Flexible Spending Account (FSA), Dependent Care & Commuters Benefits Plan

- Tax-free money for medical and dependent care expenses
- Convenient access to account funds through the Beniversal® Prepaid Mastercard®
- Commuter benefits allow employees to pay for certain workplace commuting expenses, including mass transit and parking, on a tax-free basis through payroll deductions.

Employee Assistance Program

- Free mental health services, employee webinar trainings & helpful resource
- Support Line: (833) 848-1764 or visit: eap.ndbh.com
- **Company code:** HCCC **Password:** Guest

Tuition Reimbursement Program

- Up to $9,000 towards tuition reimbursement per fiscal year.
- Degree & Certificate programs are eligible

Employee/Dependent Tuition Waiver

- Tuition waived for course taken within HCCC
- Employee and/or their dependents/Spouse are eligible
- Must be an Active Full time Employee

HCCC Employee Perks

- Free and discounted Faculty & Staff Parking
- Employee Discount Marketplace through *WorkingAdvantage*
- Auto & Home Insurance Employee discounts
    - Liberty Mutual or NJM

If you have any questions, please do not hesitate to reach out to the *Office of Human Resources*

70 Sip Ave, Jersey City, NJ 07306 O: 201-360-4070 Email: HR@hccc.edu

HR Benefits Manager, Carmen McGuire O: 201-360-4072 Email: cmcguire@hccc.edu

HUDSON COUNTY COMMUNITY COLLEGE
Office of Human Resources
70 Sip Avenue – 3rd Floor
Jersey City, NJ 07306
201-360-4070 Office
201-714-2509 Fax

TO: New Hire

FROM: Human Resources

RE: **NJ School Employees'**
Health Benefits Program (SEHBP) Enrollment

HCCC Local Education Employees

The New Jersey Employees' Health Benefits Program (SEHBP) and the New Jersey Division of Pensions & Benefits (NJDPB) require eligible employees to access *Benefitsolver* online, for accessing all your health benefit enrollment needs, including the fall Annual Open Enrollment period (October 1-31).

Through *Benefitsolver*, you can access information about your health benefits and complete your enrollments online. You can view your coverage, effective dates, who is covered under your plan and have access to live chat with any questions you may have, in reference to your SEHBP coverage. *Same access is available for those who wish to waive health & prescription coverage.*

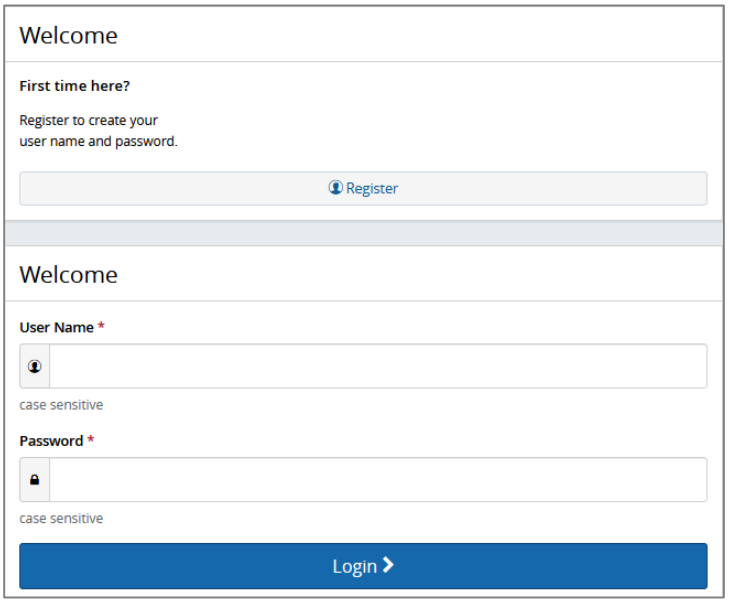
To Register:
Navigate to: http://mynjbenefitshub.nj.gov
a) Click Register
b) Enter SSN and DOB
c) Enter Company Key: SHBP/SEHBP
d) Click continue

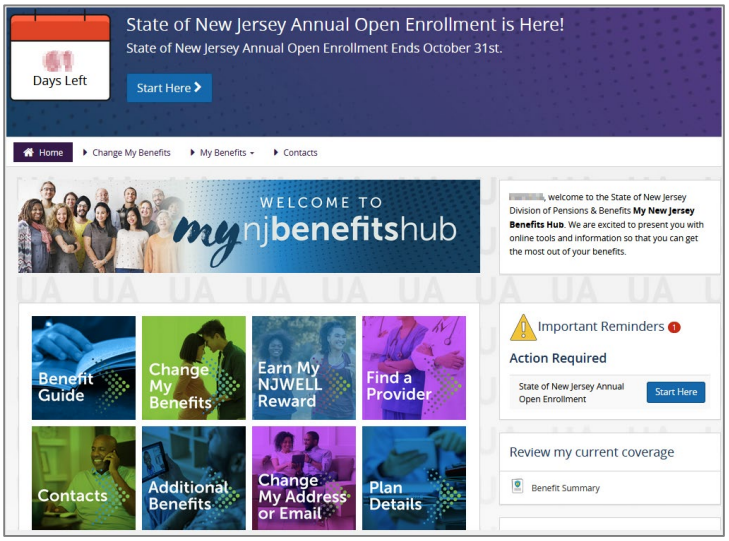
If you have trouble accessing the *BenefitSolver* website or have any questions in regards to your benefits, please do not hesitate to contact the HR Benefits Manager.

Thank you,
Office of Human Resources

How to access your benefits

mynjbenefitshub





HOW TO LOGIN:

Navigate to: http://mynjbenefitshub.nj.gov and click Register.

Enter Social Security Number and Date of Birth.

Company Key = SHBP/SEHBP

You may also log into the Benefitsolver website through the myNewJersey portal. At the bottom of the screen along with your MBOS and EPIC button, you'll see a new button that reads "Benefitsolver".

LET'S KEEP IN TOUCH

You'll be asked to provide an email address so we can send you the latest information on your benefits, including **Annual Open Enrollment Information.**

DISCOVER YOUR SITE

Explore the site to learn about your benefits. You'll find lots of helpful information in the **Reference Center**.

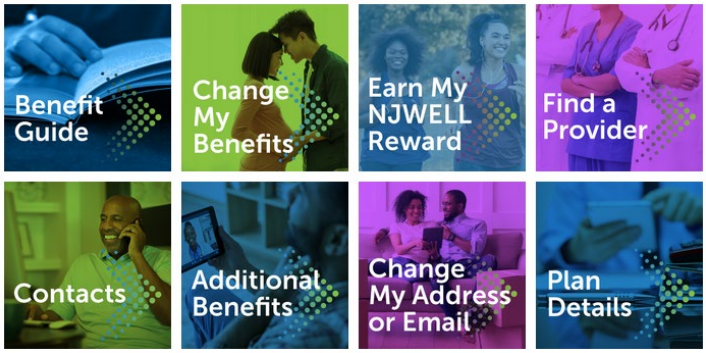
REVIEW YOUR BENEFITS

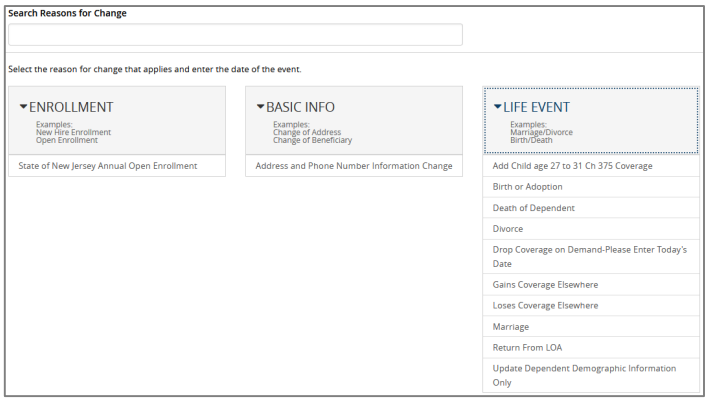
Click the **Benefit Summary** button on the home page to review your personal information, your covered dependents, and your medical, prescription, and dental plan details.

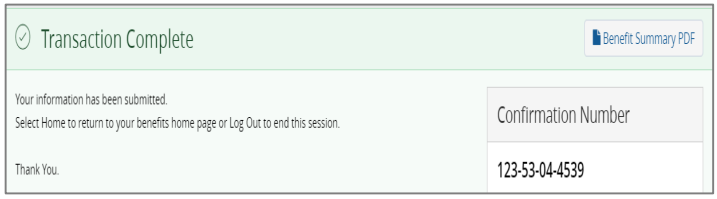
FOR HELP

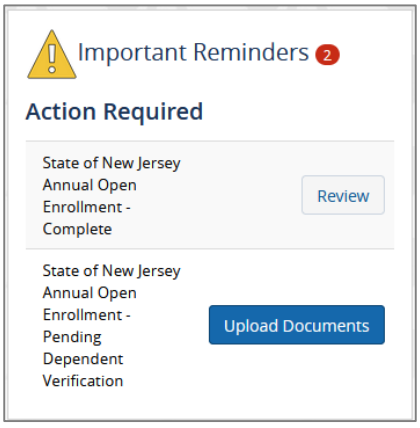
Sofia, your personal benefits assistant, can answer questions and guide you through the site.

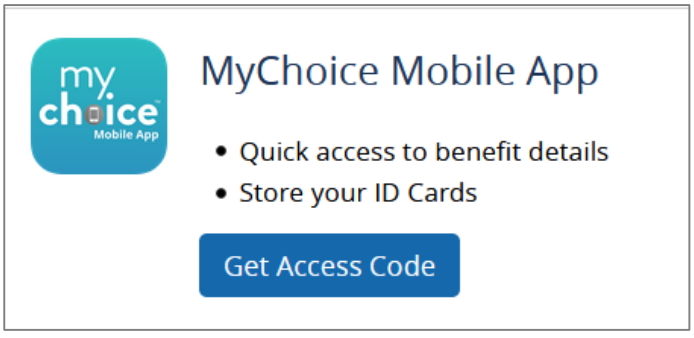
Contact your local Human Resources Department, Benefits Administrator, or your Certifying Officer for additional assistance.











CHANGE YOUR BENEFITS OR INFORMATION

To report a Qualifying Life Event, such as a Marriage or Birth/Adoption in the last 60 days, start by clicking the **Change My Benefits** button.

Select your Life Event from the **Life Event** box and enter the effective date of the change.

To change your contact information, start by clicking the **Change My Address or Email** button.

CONTINUE YOUR CHANGE

The next set of screens will walk you through your enrollment step by step, showing you the available options relevant to the change you'd like to make.

Make sure your personal information, elections, and dependents are accurate, then click **Looks Good!**

To complete your transaction, click **Approve**. On the Confirmation screen, click **I Agree.**

If you've added new dependents, you will be prompted to provide supporting documentation. Your employer will verify all uploaded documents before your dependent is approved.

When your enrollment is complete, you will receive a confirmation number and can print your **Benefit Summary** for your records.

AFTER YOU ENROLL

Return to the Home page to check for any additional tasks needed to complete your enrollment. View or download your Benefit Summary, and download the **MyChoice Mobile App**.

Visit this site anytime you want to learn more about your benefits or even search for a new provider and book an appointment using **Amino!**

amino

INDIVIDUAL ENROLLMENT/CHANGE FORM

FOR VISION COVERAGE

(Please Print or Type)

EMPLOYER (GROUP) NAME Hudson County Community College			GROUP NO. 4079 0000 01 ☐ 4079 0000 99 ☐ Cobra
EMPLOYEE LAST NAME	**FIRST**	**MI**	**DATE OF BIRTH**

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER __ __	GENDER ☐ Male ☐ Female	CONTRACT TYPE REQUESTED ☐ Employee (S) ☐ Employee + Spouse (L) ☐ Employee + Child(ren) (E) ☐ Employee + Spouse + Child(ren) (F)
EFFECTIVE DATE OF COVERAGE *OR* CHANGE		**DATE OF HIRE**

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ACTION CODES FOR CHANGES

THIS CHANGE IS FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ DEPENDENT(S)

TYPE OF CHANGE: ☐ NEW ENROLLMENT ☐ CHANGE OF ADDRESS ☐ NAME CHANGE ☐ REINSTATEMENT ☐ CHANGE TO COBRA

☐ ISSUE CARD ☐ CANCEL COVERAGE ☐ NAME CHANGE, FORMERLY _____

LAST NAME	FIRST NAME	INITIAL	M / F	DATE OF BIRTH	STUDENT (Y/N)
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

EMPLOYEE SIGNATURE: **X** _____ DATE: _____

EMPLOYER SIGNATURE: **X** _____ DATE: _____

www.e-nva.com

NATIONAL VISION ADMINISTRATORS, L.L.C.
1200 Route 46 West
Clifton, NJ 07013

Toll Free: (800) 672-7723

This document has been printed on recycled paper.

DELTA DENTAL®

Enrollment/Change Request

Employer Group Information – To be completed by Employer

Group Name	Group Number	Sublocation/Store location
HCCC	07563	00001

(A) Type of Activity – To Be Completed by Employer. Refer to instructions on back before completing this form. Print clearly.

1. Enrollment ( ) New Enrollee / Subscriber **Effective Date** ___/___/___ **Date of Hire** ___/___/___

2. Change – Check all that apply	Date of Event	Reason
(☐) Add Spouse	__/__/__	_____
(☐) Add Domestic Partner	__/__/__	_____
(☐) Add Dependent Child	__/__/__	_____
(☐) Name Change	__/__/__	_____
(☐) Change Plan	__/__/__	_____
(☐) Other	__/__/__	_____
(☐) Add/Change Office ID Numbers	__/__/__	_____

3. Remove or Terminate – Check all that apply	Effective Date	Reason
(☐) Remove Spouse*	__/__/__	_____
(☐) Remove Domestic Partner*	__/__/__	_____
(☐) Remove Dependent Child*	__/__/__	_____
(☐) Employee Withdrawal/Termination	__/__/__	_____

NOTE: Employee must be enrolled for spouse/dependents(s) to have coverage.

*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of coverage, i.e. COBRA, State, total disability. Not all options are available or applicable. Contact Employer for available options.

Coverage for: **(◯) Employee** **(◯) Dependents**

Length of Continuation: (◯) 12 months (◯) 18 months (◯) 29 months (◯) 36 months (◯) Total Disability* Attach proof of total disability

Date of Loss of Coverage: __/__/__ Date of Qualifying Event: __/__/__

Billing: (◯) Home (◯) Group

(B) Employee Information – Complete Sections (B-G)

Last name, First name, MI _____ Social Security Number _____ Home Telephone _____

E-mail Address _____ Home Address _____ Apt # ____ City, State _____ Zip Code _____

Employer Name _____ Work Telephone _____ Work Address _____

City, State _____ Zip Code _____ Date of Employment __/__/__Hours Worked per week _____

(C) Plan Option – Your selection must be offered by your Employer Check one: (◯) Delta Dental Premier® (◯) Delta Dental PPO (◯) Advantage Program (◯) Delta Dental PPO plus Premier (◯) DeltaCare

(D) Individuals Covered – List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. (Attach proof if full-time post-secondary student. Attach proof of disability.)

	(A) Add (C) Change (R) Remove	Last Name First Name, MI	Sex M F	Birthdate MM/DD/YYYY	Social Security Number	Other Health Coverage	Previous Coverage Check if Yes
Employee	_____	_____	____	__/__/____	_____	_____	☐
Domestic Partner (If Coverage offered)	_____	_____	____	__/__/____	_____	_____	☐
Spouse	_____	_____	____	__/__/____	_____	_____	☐
Child	_____	_____	____	__/__/____	_____	_____	☐
Child	_____	_____	____	__/__/____	_____	_____	☐
Child	_____	_____	____	__/__/____	_____	_____	☐
Child	_____	_____	____	__/__/____	_____	_____	☐

(E) Other/Previous Insurance

Is your spouse employed? (◯) Yes (◯) No If "Yes", give name and address of your spouse's employer.

_____

If “Yes” to Other Health Coverage (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID#.

_____

If “Yes” to Previous Coverage, identify names(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number.

_____

(F) Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? (O) Yes (O) No If “Yes”, who and at what address?

_____

Explain the circumstances

_____

If any dependent’s last name differs from yours, explain the circumstances.

_____

(G) Employee Signature *If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Customer Service Agent at 1-800-452-9310 before signing this form.*

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee enrollment/change request. I authorize deductions from my earnings for any required contributions.

Employee Signature – Required _____ Date __/__/__ E-mail Address _____

(H) Employer Verification – To be Completed by Employer

Employer Signature – Required _____ Title _____ Date __/__/__

Instuctions

Employer

*Complete the Employer Group Information in the upper left corner of the form.
*Section A - Type of Activity:Check boxes indicating reason(s) for submitting application.
*Complete Section (H) – Employer Verification (in the upper left corner of the second page)of the form.
*Employer must complete this section for all new enrollments, coverage changes and terminations.
*Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee – Complete Sections (B-G)

Section (B) – Employee Information

- Complete all information in order for your application to be processed.

Section (C) Plan Option:

Check one Plan option box ( ) Delta Dental Premier ( ) Delta Dental PPO
( ) Delta Dental POS ( ) Delta Dental PPO Advantage Program ( ) DeltaCare
Select only an option offred by your employer.

Section (D) – Individuals Covered:

- Add/Change/Remove – Use “A”,“C”,or”R” to indicate wqhether you are adding,changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex,Birthdate,and Social Security number for each individual listed.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school **or its authorized representative** confirming full-time student status. If dependent is disabled and being contiuned beyond the limiting age, attach proof of disibility.
- If you or your dependent(s) have other Health coverage, check off the “Yes” box(es) and complete Section (F) – Other/Previous Insurance.
- From the appropriate provider directory, locate the office ID number for the dentist (if applicable). Indicate office ID number selection(s) on the form.

Section (E) – Pre-Existing Conditions Statement

- Complete this section for all new enrollments. Exceptions: For Small Employer Group coverage, this section must be completed only by persons enrolling in the group coverage in a group of 2-5 employees and by late entrants.

Section (F) – Other/Previous Insurance

- Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section (G) – Dependent Information

- Complete this section for all new enrollments or coverage changes.

Section (H) – Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request Form in order for it to be processed.

Section (I) – Employer Verification

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request Form in order for it to be processed.

Conditons of Enrollment

Application Acknowledgment and Agreements

1. On behalf of myself and the dependents listed on the reverse side I agree to or with the following:
   a)I authorize the sources stated below to give Delta Dental of New Jersey, Inc. or any consumer reporting agency acting on its behalf, information about me and my minor childern, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or medical condition. Authorization sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier, any consumer reporting agency; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not afect any action which Delta Dental of New Jersey, Inc. has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in a Delta Dental of New Jersey, Inc. plan or group policy coverage is provided by Delta Dental of New Jersey, Inc. in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Delta Dental of New Jersey, Inc.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request form for a health benefits plan is subject to criminal and civil penalties.

Enrollment/Change Form
Flexible Spending Accounts

Employer

Employee Name

Member ID *(set by your employer. Typically an employee ID or SSN.)*

Street or PO Box

City State ZIP

Effective Date of Enrollment *(MM/DD/YYYY)*

Hire Date *(MM/DD/YYYY)*

Birth Date *(MM/DD/YYYY)*

Email Address

Phone Number

Employment Status: ☐ Full Time ◯ Part Time

Please enter your FSA election(s):

	Per Pay Deduction	Plan Year Election
☐ **Medical FSA** *Note: If you or your spouse has a Health Savings Account (HSA), contributions cannot be made to the HSA while there is coverage under a Medical FSA.*		
◯ **Limited Medical FSA** (reimburses dental, vision and/or post-deductible expenses as allowed by your plan) *Note: You cannot elect this account if you elect a Medical FSA. You can elect this account if you are covered under an HSA. In order to accurately track eligible expenses, apply them to the correct deductible threshold and ensure reimbursement of eligible post-deductible expenses, you must indicate the level of coverage you have under your health insurance.* ☐ Single ◯ Family		
☐ **Dependent Care FSA**		

This is a:

☐ New enrollment ◯ Change in previous enrollment

If this is a change in enrollment, please check the event that triggered this change:

NOTE:

- *An election can only be changed if the change in status affects eligibility for that coverage.*
- *Any change in election must be consistent with the change in status and the change in eligibility*

☐ Participant's termination of employment.

◯ Change in employment status of spouse or dependent (including termination or commencement of employment).

◯ Change in employee's legal marital status (including marriage, divorce, death of spouse, legal separation, annulment).

◯ Change in number of tax dependents (including birth, adoption, placement for adoption, death).

◯ Change in work schedule (reduction or increase in hours by employee, spouse or dependent, including a switch between full-time and part-time, a strike or lockout, and commencement of or return from an unpaid leave of absence).

◯ Change in residence or worksite (of employee, spouse, or dependent).

◯ Dependent satisfies or ceases to satisfy dependent eligibility requirements (attainment of age, student status, etc.).

◯ Change in dependent care cost or provider (for Dependent Care FSA elections only).

◯ Other:

Enrollment/Change Form

Flexible Spending Accounts

Please certify the following:

I have received and read the printed material which explains my plan and my options under it. I understand that any expenses paid under this plan must be eligible expenses as governed by Internal Revenue Service (IRS) regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an irrevocable election for the current plan year. Any choices above may be modified only as defined in the plan. Moreover, I authorize the amount(s) above to be deducted from payroll as indicated. I also understand that unused amounts in any Flexible Spending Account may be forfeited after the time frame indicated in the Plan Highlights.

I understand that Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If a Beniversal® Prepaid Mastercard® is associated with my Flexible Spending Account:

- I authorize the issuance of a Beniversal Card. I agree to use this card only for eligible medical expenses under the plan for me or a qualifying individual and to be bound by all provisions of the Cardholder Agreement and card promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Cardholder Agreement, my account may besuspended and I will reimburse the plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck onan after-tax basis. I also authorize expenses for replacement cards and paper followup requests to be deducted from my account balance as needed.

- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such followup documentation to Benefit Resource upon request.

Signature

Date *(MM/DD/YYYY)*

adafsf

EMPLOYERS ONLY - This section must be complete for employee to be enrolled

Deduction Cycle: ○ Monthly ○ Semi-monthly ○ Bi-weekly ○ Weekly

☐ Other:

Pay date of first FSA deduction(s):

FSA Pay Dates This Year:

Change in Health Insurance level of Coverage: ☐ Single ○ Family

Insurance Coverage Code: ☐☐☐☐☐☐

This information is required for Beniversal Cards. The six digit code must match a code on your Group Insurance Form. Note: If employee is not insured through an employer sponsored health insurance plan, enter NOMED.

Submit this document by:

Fax:
(585) 427-9320

Mail:
Benefit Resource, LLC
PO BOX 642
Willow Grove, PA 19090

The employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.

ENROLLMENT FORM

COMMUTER BENEFIT PLAN

(PLEASE PRINT CLEARLY)

Benefit Resource, Inc.
245 Kenneth Drive
Rochester NY 14623-4277
Phone: (800) 473-9595
www.BenefitResource.com

EMPLOYER:

EFFECTIVE DATE OF ENROLLMENT: / /

A. EMPLOYEE INFORMATION

Member ID:

Employee Name: (Last) (First) (MI)

Home Address: (Street) (Apt #)

(City) (State) (Zip Code)

Home Phone #: Birth Date: / / Gender: ☐ Male ☐ Female

Hire Date: / / Employee Status *(please check one)*: ☐ Full-Time ☐ Part-Time

Email Address: _____

(Note: Benefit Resource, Inc. will only use your email address to communicate with you regarding your plan.)

B. COMMUTER BENEFIT PLAN (CBP) ACCOUNTS

Please enter your CBP election(s):

Type of Account	**Monthly Election**
☐ Parking	$ _____
☐ Mass Transit	$ _____

C. EMPLOYEE CERTIFICATION *Return signed form to your employer.*

- I have received and read the printed material which explains my Commuter Benefit Plan and my options under it. I understand that any expenses paid under this plan must be eligible workplace commuting expenses as governed by Internal Revenue Service regulations and must not be reimbursed from any other source. I also understand that by signing and submitting this enrollment form, I am making an election that will remain effective until a change form is submitted during open enrollment or when a permissible change has occurred. Any choices above may be modified only as defined in the plan.
- I authorize the amount(s) above to be deducted from payroll as indicated and also authorize any necessary advance on salary deduction (as described herein).
- I authorize the issuance of a Prepaid Mastercard® ("Card"). I agree to use the Card only for eligible plan expenses and to be bound by all provisions of the Cardholder Agreement sent to me with my Card. Furthermore, I understand that if my Card is used for expenses other than those defined in the plan or if I violate the terms of the Cardholder Agreement, my account may be suspended and I will reimburse the plan for the expenses. I also agree to have any non-approved expense and/or applicable replacement card expense deducted from my paycheck on an after-tax basis as an advance on salary.
- I understand that Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. I also understand that I may be required to provide identifying information (e.g. Member ID, address and date of birth) when making inquiries about my Card. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

Signature: _____ Date: _____ / _____ / _____

D. PAYROLL DEDUCTION INFORMATION *Employer must complete this section for employee to be enrolled.*

- **Deduction cycle:** ☐ monthly ☐ semi-monthly ☐ bi-weekly *(2 per month)* ☐ weekly *(4 per month)*
- **Pay Date of first CBP deduction(s):** _____/_____/_____
- **Card Issue Month:** _____

Your Prepaid Mastercard is issued by The Bancorp Bank pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark of Mastercard International Incorporated. The Bancorp Bank; Member FDIC.