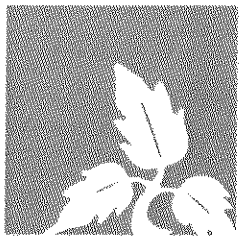

2014 OHIO COMMUNITY POOLED FLEXIBLE-SPENDING TRUST

ACCOUNT AGREEMENT

This is an Application by the Qualified Donor identified below to establish an Account within the Ohio Community Pooled Flexible-Spending Trust (the "Trust"), to provide benefits for the Individual with Disabilities identified below. The Account so established will be administered in accordance with the terms of the Trust, as amended from time to time. The Qualified Donor understands and acknowledges that, once accepted, the funds placed in this Account may not be withdrawn, except in accordance with the terms of the Trust.

Capitalized and other terms used in this Account Agreement shall have the same meaning as in the Agreement of Trust of the Ohio Community Pooled Flexible-Spending Trust.

1. TRUSTEE: KEY BANK, N.A.

2. DISTRIBUTION TRUSTEE: THE DISABILITY FOUNDATION, INC.

3. QUALIFIED DONOR:

Name: _____
Address: _____
_____
Telephone: _____
Cell/Mobile: _____
Work Phone: _____
Relationship to Individual with Disabilities: _____
Social Security Number: _____

4. INDIVIDUAL WITH DISABILITIES:

Name: _____
Address: _____
_____
Telephone: _____
Cell/Mobile: _____
Work Phone: _____
Social Security Number:_____
Date of Birth: _____

Receiving: _____ Medicaid _____ Supplemental Security Income (SSI)

5. PERSONAL REPRESENTATIVE

The Personal Representative is responsible for providing information and updates about the Individual with Disabilities, including his/her address, telephone, and benefits and services (s)he is receiving. The Personal Representative is also responsible for asking the Trust to purchase items for the Supplemental Needs of the Individual with Disabilities, and providing supporting information.

PERSONAL REPRESENTATIVE

Name: _____
Address: _____
_____
Telephone: _____
Cell/Mobile: _____
Work Phone: _____
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 Qualified Donor names the following Successor Personal Representatives to serve (in the order listed):

Name: _____
Address: _____
_____
Telephone: _____
Cell/Mobile: _____
Work Phone: _____
Relationship to Individual with Disabilities: _____

Successor Personal Representatives (Continued)

Name: _____
Address: _____
_____
Telephone: _____
Cell/Mobile: _____
Work Phone: _____
Relationship to Individual with Disabilities: _____

6. PROPERTY TRANSFERRED BY THE QUALIFIED DONOR:

_____

_____

_____

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

It is acknowledged and agreed that twenty-five percent of any funds remaining in the Account of the Individual with Disabilities after his/her death will be retained by The Disability Foundation, Inc., for Disability Programs and Services. The Qualified Donor requests, by indicating below, that any other funds remaining in the Account be used as follows:

CHOOSE EITHER (a) OR (b):

(a) All remaining funds to be retained by the Trust, for Disability Programs and Services.

_____ (Initials of Qualified Donor)

OR

(b) All funds to re-pay Medicaid, as reimbursement for benefits provided to the Individual with Disabilities

_____ (Initials of Qualified Donor)

If funds remain after Medicaid is reimbursed in full, such funds shall be paid as follows:

Primary:

_____

_____

The Disability Foundation per cent (_____%)

Secondary:

_____

_____

The Disability Foundation per cent (_____%)

8. APPLICATION

The Qualified Donor hereby applies to establish an Account in the Trust for the Individual with Disabilities identified above, this ____ day of _____, 20 __.

_____
Qualified Donor

9. APPROVAL BY THE DISTRIBUTION TRUSTEE

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

THE DISABILITY FOUNDATION, INC.

By: _____

Its: _____