Vital ASO Agreement

SCHEDULE B

EMPLOYEE INFORMATION

TOTAL NUMBER OF ELIGIBLE EMPLOYEES: _____

TOTAL NUMBER OF PARTICIPATING EMPLOYEES: _____

EMPLOYEE CLASSES (Select as appropriate):

DESCRIPTION	Executive	Management	Other Full-Time	Part-Time	OTHER
CLASS CODE	**1**	**2**	**3**	**4**	**5**

**** In the table below, please check to indicate if individual is an employee or dependent. Please list spouse and/or dependents immediately below the Employee's name.**

STATUS	LAST NAME	FIRST NAME	INIT.	EMPLOYEE CLASS CODE	DATE OF BIRTH	SEX
EMP DEP	(Please Print)	(Please Print)		(See table above)	(mm/dd/yy)	M F
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Personal information, including that listed above as well as employee compensation information, is collected from the Employer for the setup and administration of Employer's Employee Benefit Plan. Personal information of employees is protected by Vital Health Savings Plan's privacy policy. Contact Vital Health Savings Plan for further details.