



REQUEST FOR DEBIT CARD

Instructions: To receive a card for your dependent or to replace a lost or stolen card, please complete the following. Be sure to provide all information requested by this form. If the form is incomplete, it will be returned to you. Print or type the information requested. Then date and sign the form. You may fax or email signed request form.

Employee Name: _____ SS#: _____

Address: _____

Employer Name: _____ Group#: _____

Please Note: Replacement Cards – VISA charges a \$5 reissue fee for replacement cards (no fee for replacement due to card expiration date). This fee will come directly out of your spending account and qualifies as a valid expense through the plan.

Is this request for a replacement of an existing card? Yes No

If "Yes", reason for replacement: Lost Stolen Other: _____

Dependent Name: _____

Dependent SSN: _____ Dependent's Date of Birth: _____

Is the Dependent a spouse? Yes No If "No", relationship with Dependent: _____

To the best of my knowledge and belief, my statement in this Debit Card Request Form is complete and true. I certify that I or my Dependent will use the card for expenses that qualify as valid expense under my Employers Plan, and that I have not been reimbursed previously under the Employers Plan or any other Health plan, FSA plan or HRA plan, nor do I expect any of these expenses to be reimbursable elsewhere. If the reimbursement is for prescription or over the counter drugs, I certify that such drugs are not for cosmetic purposes. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. I understand that if the expenses are deemed ineligible for reimbursement under the Employers plan that it is my responsibility to reimburse the plan immediately for the ineligible portion of the transaction. I also understand that if the card is used again for an ineligible expense, the Debit Card will be suspended for the remainder of the plan year. In this event, you must obtain future reimbursements by submitting a manual request for reimbursement form along with the appropriate receipt(s).

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or health care fraud under state and/or federal law. To report suspected fraud, call 1-877-9FRAUD 9 (1-877-937-2839).

Employee Signature

Date

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