REQUEST FOR DEBIT CARD

Instructions: This form is to be completed if requesting additional cards or need to replace an existing card for one of the reasons listed below. 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, date and sign the form. You may fax or email the signed request form.

Employee Name: _____ PID#: _____

Address:_____

Employer Name: _____ Group#: _____

Please Note: Replacement/Additional Cards – VISA charges a $5 reissue fee to either replace or receive additional cards (there is no fee for replacement due to the card expiration). The fee will come directly out of your Health Care Spending Account and qualifies as a valid expense through the plan. By completing and signing this form you agree to the reissue fee.

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

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

Is this a request for an additional card for a dependent? ❑ Yes ❑ No

Are you requesting the card be issued in the dependents name? ❑ Yes ❑ No

If Yes – please provide the dependent information.

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 my Dependent or I will use the card for expenses that qualify as valid expense under my Employers Plan. I understand that if the expenses are deemed ineligible for reimbursement under my 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 may only 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

Specialty Services Unit •1975 Tamarack Road • P.O. Box 1096 • Newark, OH 43058-1096
FSA/HRA Phone (800) 297-1829 • Fax (740) 522-7483 • www.medben.com • admin@medben.com