

# Benefits Card Election Form

## Employee Information

Social Security # or Employee ID:  Date of Birth:

Employer Name:

First Name:  Middle Initial:  Last Name:

Employee Home Address:

City:  State:  Zip:

Home Phone #:  E-Mail:

Help us go green! If provided, we will use your email as our primary method of contact.

## Employee Elections

**\*Cards are valid for 3 years from date of issue.\***

### My Card

- I do **NOT** elect to use the Benefit Card. All cards from previous years will be deactivated.
- I am a **New Participant** and I elect to be issued a Benefits Card.
- My card has been **lost/destroyed**. Please re-issue a new Benefits Card.

### Dependent Card

Dependent <input type="text"/>	SSN <input type="text"/>	Date Of Birth <input type="text"/>
<small>Print name</small>	<small>Social Security Number</small>	
Dependent <input type="text"/>	SSN <input type="text"/>	Date Of Birth <input type="text"/>
<small>Print name</small>	<small>Social Security Number</small>	
Dependent <input type="text"/>	SSN <input type="text"/>	Date Of Birth <input type="text"/>
<small>Print name</small>	<small>Social Security Number</small>	

- I would like to have a second card issued to my dependent, who's over the age of 18, who's name and social security number are indicated above.
- My dependent's card has been **lost/destroyed**. Please issue a new card to the dependent above.
- Please deactivate my dependent's card(s).

**\* Benefit Cards are automatically re-issued upon expiration and are pre funded with your health care annual election amount. Dependent care annual elections are not pre funded.\***

#### Benefits Card Certification

I acknowledge that I will agree to the terms and conditions of the Cardholder Agreement received with my BENEFITS CARD and certify that I will only use the card for qualified health care and/or dependent care expenses. I further certify that I will not seek reimbursement under any other health plan coverage for claims that have been paid for by the card, nor will I use the card for expenses that have been paid by any other health plan benefit. I acknowledge that I will, upon request of the Plan administrator, provide required documentation of expenses.

Failure to submit sufficient documentation for your Benefit Card transaction may result in deactivation of your card.

Employee's Signature:  Date: