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www.flex-admin.com

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.

Please submit your completed form to BenefitsCard@flex-admin.com or fax to 757-431-1155.

Employee's Signature: Date: