The Preferred Group
PO Box 15136
Albany, NY 12212-5136
(800) 573-7474
www.thepreferredgroup.com

Request for the Prepaid Benefits Card

Employer Name: _____

Participant Name: _____

SSN: _____

Participant Email Address **(Required)**: _____

Date of Birth: _____

The benefit card(s) are to be used for eligible expenses allowed through my employer's plan. I further understand that I am solely responsible for the validity of the charges and **I am to retain all originals or copies of all documents of which charges appear on the debit card.** I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other health coverage or if the charges are deemed to be unreimbursable, I shall return the monies paid to me by this plan, for re-crediting of my account.

I will have on-line access to my account information. General communications regarding my account and any requests for the substantiation of charges will be done via email. Requests for the substantiation of charges that are not answered/validated may result in card suspension.

I will receive two (2) benefit cards that will expire after three years. I understand the information below **must contain my spouse and/or dependent information** in order to obtain a second benefit card. **Funds will automatically be reloaded each plan year unless I submit a Termination Request form.** Cards will be received in 7-10 business days from date of enrollment. I understand that a fee of $18.00 per year will be deducted from my account at the beginning of the plan year.

Dependent Name: _____

Dependent SSN: _____

Date of Birth: _____

Home Address: _____

_____

Relationship to Participant: _____

Please see reverse side for dependent information

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In addition, please issue a debit card to the following dependents. I am aware that a $5 per card fee will be deducted from my Flexible Spending Account Balance.

Dependent Name: _____

Dependent SSN: _____

Date of Birth: _____

Home Address: _____

_____

Relationship to Participant: _____

Dependent Name: _____

Dependent SSN: _____

Date of Birth: _____

Home Address: _____

_____

Relationship to Participant: _____

I would like to request the Prepaid Benefits Debit Card. I intend to use the debit card for items and services that are reimbursable through my employer's flexible spending plan. I further understand that I am solely responsible for the validity of the charges and I am to retain all originals or copies of all documents of which charges appear on the debit card. I also certify that none of these expenses have been previously submitted for reimbursement. I understand that should these expenses be reimbursed to me by other heath or benefit coverage or if the charges are deemed to be unreimbursable, I shall return the monies paid to me by this plan, for re-crediting of my account. I understand that my employer does reserve the right to withhold these amounts from my pay. I understand that a pre-tax annual fee of $18.00 will be deducted from my Flexible Spending Account and an additional $5.00 for each Spousal/Dependent card.

Employee Signature_____ **Date**_____