Dependent Card Request Form

EMPLOYEE NAME (PRINT) **SOCIAL SECURITY #**

FIRST *LAST* *MI*

I am a participant in one or more of the Benefit Plans offered by my Employer. Please issue an additional debit card for use by my eligible dependent. In making this request, I understand, accept, and agree to the following:

1. I will receive a debit card ("Card") that is strictly to be used with my Benefit Plan to pay for my out of pocket expenses that are eligible under one or more of the Benefit Plans I am enrolled in. And that such expenses are not payable by, nor will I be seeking payment from any other source;
2. The Card may only be used at medical and/or licensed dependent day care providers;
3. I am fully responsible for my own and my dependent's use of the Card as stipulated in the cardholder agreement that will come with the Card;
4. I will be responsible to immediately refund to the Plan, either directly or through employer payroll deductions made by my Employer hereby authorized, any ineligible Card transactions made by either myself or my dependent spouse listed below;
5. I may be subject to Federal Income Taxes and penalties based on any ineligible Card transaction made by myself or my dependent;
6. I agree to notify MEDCOM immediately if separated or divorced from my spouse or if my dependent ceases to be my tax dependent; and,
7. I agree to pay the $7.50 fee for this additional debit card and understand that this fee will be automatically deducted from the Account.

With full understanding of the above, I request that you issue an additional debit card for the following dependent:

Dependent's Name (Print) **Dependent's Social Security Number**

Date of Birth **Relationship to Employee** FSA ☐ DCA ☐ **Choose Plan (Check all that apply)**

Employee Signature **Date**

Phone: (800) 523-7542, option 1
Fax: (877) 723-0149
MedcomReceipts@medcombenefits.com