





# Benefits Card Additional Card Request

## Employee Information (All Fields Required. If more than 2 cards are needed, please complete additional form(s) as needed.)

Employee Last Name	First Name	Middle Initial	Social Security Number - -
Employer Name	Client Code	Daytime Phone Number ( )	

## First Additional FSA Card User Information

Last Name	First Name	Middle Initial	Social Security Number - -
Relationship to Employee (check one box) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent or Adult Child 18 years of age or older			Date of Birth / /
I agree to use the FSA Benefits Card only for eligible medical care expenses under the Health Care Flexible Spending Account Plan of the Employee listed above and as defined in Section 213(d) of the Internal Revenue Code. I further certify that I will not seek reimbursement from any other plan for any medical expense paid with the FSA Benefits Card, nor will I claim any federal income tax deduction or credit with respect to such medical expense.			
First Additional User Signature <b>X</b> _____			Date _____

## Second Additional FSA Card User Information

Last Name	First Name	Middle Initial	Social Security Number - -
Relationship to Employee (check one box) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent or Adult Child 18 years of age or older			Date of Birth / /
I agree to use the FSA Benefits Card only for eligible medical care expenses under the Health Care Flexible Spending Account Plan of the Employee listed above and as defined in Section 213(d) of the Internal Revenue Code. I further certify that I will not seek reimbursement from any other plan for any medical expense paid with the FSA Benefits Card, nor will I claim any federal income tax deduction or credit with respect to such medical expense.			
Second Additional User Signature <b>X</b> _____			Date _____

## Employee Authorization

<p>I agree to ensure that each Additional User identified above will use the FSA Benefits Card only in connection with my employer's Health Care Flexible Spending Account Plan (the "Plan") for eligible medical care expenses, as defined in the Plan and in Section 213(d) of the Internal Revenue Code. I certify that each Additional User qualifies as either my spouse (as defined by Federal laws), dependent or adult child (as defined by the Plan) that is 18 years of age or older. I further certify that neither I nor any Additional User shall seek reimbursement from any other plan for any medical expense paid with the FSA Benefits Card, nor claim any federal income tax deduction or credit with respect to such medical expense.</p> <p>Upon request, one card for each eligible adult child, dependent, or spouse will be provided at no charge. I acknowledge that any request to replace a previously issued card will result in my being charged a \$10.00 fee for each card replaced. This fee will automatically be deducted from my Flexible Spending Account balance.</p>
Employee Signature <b>X</b> _____ Date _____

**Please return completed form to Ceridian via fax at 866-377-4261.**

You may also mail to: **Ceridian, P.O. Box 534200, St. Petersburg, FL 33747.**

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If for any reason an additional card cannot be issued, a Ceridian Representative will contact you.

