Ph: 800-437-FLEX or 757-340-4567
P.O.Box 8188 • Virginia Beach, VA 23450
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 ____ (Print name) SSN ____ (Social Security Number) Date Of Birth ____

Dependent ____ (Print name) SSN ____ (Social Security Number) Date Of Birth ____

Dependent ____ (Print name) SSN ____ (Social Security Number) Date Of Birth ____

☐ 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: ____

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