# FLEXIBLE SPENDING ACCOUNT CARD REQUEST FORM (FSA)

## EMPLOYEE INFORMATION

**Employer:** **University Medical Center of El Paso** ☐ **El Paso Children's Hospital** ☐

**Member Last Name:** **Member First Name:**

**Social Security Number:** **Daytime Phone Number:**

**Address:** **Email Address:**

## REASON FOR FSA CARD REQUEST

**STOLEN CARD:** ☐ **LOST CARD:** ☐ **DESTROYED CARD:** ☐

**DEPENDENT CARD REQUEST:** ☐ **SPOUSE CARD REQUEST:** ☐

If you are requesting a card for your dependent/spouse, please fill out the section below. Please list an eligible dependent or legal spouse, as defined by IRS Code 152, to whom the Benefit Card should be issued. **If you need additional cards for each dependent, please fill a separate form for each dependent.**

**Last Name of Dependent/Spouse:** **First Name of Dependent/Spouse:**

**DOB:** **SSN:**

**Address:**

**Apt:**

**City:** **State:** **Zip Code:**

## EMPLOYEE AUTHORIZATION

**By providing dependent/spousal information and signing the *FSA Card Request Form*, I authorize and understand that one additional Benefit Card will be issued under the FSA System. A card will only be issued to a legal spouse as defined by IRS Code 152. Use of card will directly affect my account balance. I am fully responsible to ensure that my spouse/dependent complies with the rules and regulations regarding the use of the card as outlined in the cardholder agreement to which I agree to be bound.**

**Signature**_____**Date:**_____

**Mail to:**
**Preferred Administrators**
**1145 Westmoreland Drive**
**El Paso, TX 79925**
**Phone: 915-532-3778**
**Fax to: 915-298-7863**