



## 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: \_\_\_\_\_

### 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: \_\_\_\_\_

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 ext. 1529  
Fax to: 915-298-7863