



FSA CARD REQUEST FORM

EMPLOYEE INFORMATION

Employer: University Medical Center of El Paso El Paso Children's Hospital
Employee Last Name: Employee 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:
Social Security Number:
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