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