

Attn: FSA Department  
P.O. Box 5689  
Irvine, CA 92616  
Phone: 888.289.4062 • Fax: 800.930.0437  
E-mail: [fsa@proviewbenefits.com](mailto:fsa@proviewbenefits.com)  
[www.proviewbenefits.com/login/](http://www.proviewbenefits.com/login/)

**INSTRUCTIONS:**

- Complete ALL SECTIONS of this form to ensure timely and accurate processing of the request.
- You may send your completed form via any one of the following options: fax, e-mail, postal mail, or by logging onto your account at [www.proviewbenefits.com/login/](http://www.proviewbenefits.com/login/). Faxed forms must be legible for processing. If sending this form via e-mail, note that there is a 3MB size limit to e-mail attachments.

**NOTE:** There is a transaction fee per flex debit card taken directly from your FSA account in the following situations:

- Replacement card (\$10.00)
- Secondary/additional card for your dependent (\$5.00)

**PART A : YOUR INFORMATION**

EMPLOYER NAME			
EMPLOYEE NAME (First, Middle, Last)			SOCIAL SECURITY NUMBER (optional)
STREET ADDRESS		CITY	STATE ZIP
<input type="checkbox"/> NEW ADDRESS			
DAYTIME PHONE NUMBER (with area code) ( ) -	EVENING PHONE NUMBER (with area code) ( ) -	E-MAIL ADDRESS	

**PART B: REQUIRED INFORMATION FOR ADDITIONAL/DEPENDENT DEBIT CARD REQUEST**

(Dependent must be at least 18 years of age)

NAME (First, Middle, Last)	SOCIAL SECURITY NUMBER	BIRTHDATE / /	RELATIONSHIP TO YOU
STREET ADDRESS	CITY	STATE	ZIP

**NOTE:** Delivery of FSA Debit Card can take up to 15 days after processing date.

**READ CAREFULLY:**

**AUTHORIZATION**

I hereby request the above FSA debit card and authorize any associated transaction fees. I understand that such fees may be automatically deducted from my flexible spending account.

I certify that 1) all expenses for which reimbursement or payment is claimed by the use of this FSA debit card are incurred during the Plan Year while I am enrolled and covered under my employer's **Flexible Benefit Plan**, 2) that such expenses have not been reimbursed, or are not reimbursable, under any other benefit plan and 3) that said expenses are limited to my maximum annual election.

I understand that I will be notified via letter when supporting documentation is required for a transaction. When requested, I will need to mail or fax the supporting documentation along with a copy of the request letter. I understand that if I fail to submit the requested supporting documentation, my FSA debit card will be suspended. I understand that if the flex debit card was used to pay for an ineligible expense, I will be notified and required to refund my flexible spending account for the ineligible expense and that my FSA debit card will automatically be suspended until the reimbursed amount has been received and processed.

**FOR DEPENDENT/ADDITIONAL FSA DEBIT CARD REQUEST:**

I request and authorize the issuance of a dependent/secondary FSA debit card on my flexible spending account. I understand that I can only have one additional FSA debit card to my flexible spending account.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date