ASIFlex Card Order Form

Complete all fields and type or print clearly.

Type of card order*	☐ First-time new card order (2 cards per set) ☐ Additional card set(s) for dependents (2 cards per set)–number of additional sets needed___ ☐ Replacement of lost/stolen card(s) ☐ Card is worn out; need a new card ***Note: New cards are issued with a 5-year expiration date. If you exhaust all funds in one year, do not destroy your card. Keep the card for use in future years as new plan year elections will be automatically loaded to the card.***				
My employer*					
My name*					
Social Security Number*		**Date of birth* MM/DD/YEAR**			
Mailing address*					
City*		**State***		**Zip Code***	
Email address*					
Cellular telephone number	*Note: Standard text message charges may apply from your wireless provider.*				

Required fields. Form cannot be processed without this information. All information, including Social Security Number, are required by the card issuer for proper identification, security and fraud prevention.

I understand:

- I will receive two debit cards, both in my name. The cards will be mailed to my home address approximately two to three weeks from the date my application is processed.
- My spouse or eligible dependent may use a card and I am responsible for its use.
- I must activate my card(s) by calling the toll-free number as provided, and I can select a PIN if I wish.
- I can sign for credit transactions or I can supply my PIN for debit transactions.
- Use of the card is optional and I can choose at each point-of-sale if I want to use the card, or file a claim.
- The IRS requires me to keep documentation of all my card transaction expenses and submit supporting documentation to substantiate certain transactions upon request. ASIFlex will notify me if documentation is required.
- It is my responsibility to request appropriate documentation from health care providers each time I use the card in order to substantiate card transactions.
- I must read my messages posted to my secure message center at asiflex.com to understand the documentation that may be required.
- If I do not supply the requested documentation as requested, IRS regulations require that the card be temporarily deactivated.
- Future claims submitted will be offset by any outstanding card transaction amount.
- Misuse of the card may result in permanent revocation and repayment of ineligible expenses.
- I must submit correct and appropriate documentation upon request.
- Additional information regarding card usage can be found online at https://asiflex.com/DebitCards.aspx

I hereby state that the above information is accurate, to the best of my knowledge. Additionally, I certify that the card will only be used to pay for eligible health care expenses as defined in the plan and IRC §213(d). I will not seek reimbursement from any other source for the expenses paid for with the card. I also acknowledge that if I do not provide requested documentation in a timely fashion, my card will be temporarily deactivated, in accordance with IRS regulations.

Participant Signature: _____ Date: _____

Typed signature will suffice.

Submit to: ASIFlex | PO Box 6044 | Columbia, MO 65205-6044 | Fax: 877.879.9038

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