ASIFlex Card Order Form

Complete all fields and print clearly.

Indicate the Type of Card Order*	☐ First-time new card order ☐ Additional card set for dependents (2 cards per set) – number of card 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.*	**Cell Carrier**			

Required Fields. Form will not be processed without this information.

I understand:

- The card is optional and I can choose at each point-of-sale if I want to use the card, or file a traditional claim.
- I may be required to provide supporting documentation to substantiate certain card transactions. ASIFlex will notify me if documentation is required.
- I must read my messages posted to my secure message center at www.asiflex.com to understand the documentation that may be required.
- I must submit correct and appropriate documentation upon request.
- It is my responsibility to request appropriate documentation from health care providers in order to substantiate card transactions.
- If I do not supply the requested documentation in the timeframe requested, my card will be temporarily deactivated as required by IRS regulations.
- 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.
- 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.
- Each employer plan is different. There may be an annual fee for the card so I must review my employer plan materials. Fees for additional or replacement card sets are $5 and will be deducted from my flexible spending account balance.
- Additional information regarding card usage can be found online at www.asiflex.com/debitcards.

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 deactivated, in accordance with IRS regulations.

Participant Signature: _____ Date: _____

FAX OR MAIL TO:
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