Contact us with questions at: 800-662-1113
Fax this completed form to: 800-240-0642

AMERICAN FIDELITY
a different opinion

REQUEST FOR ADDITIONAL **BENEFITS** DEBIT CARDS

☐ Please issue an additional Benefits Debit Card for my spouse and/or eligible dependents named below. An additional Benefits Debit Card will only be issued to dependent children that are 18 to 26 years old.

First and Last Name	SSN	Relationship
First and Last Name	SSN	Relationship
First and Last Name	SSN	Relationship

RULES OF PARTICIPATION FOR **BENEFITS DEBIT CARD**

I understand the following guidelines:

- I must keep ALL receipts/documentation and provide them to American Fidelity, as requested.
- When a dependent loses dependent status, I understand that I must notify American Fidelity immediately.
- The Benefits Debit Card may only be used at qualified medical providers.
- If the medical provider does not accept the Benefits Debit Card, I will need to pay the expense and submit the claim for reimbursement to American Fidelity manually, by mail or fax.
- If I do not respond to American Fidelity's request for receipts in a timely manner, access to my Benefits Debit Card will be blocked and I will need to pay back the amount of the expense either by check, credit card, or money order.
- If I use the card to pay for an ineligible expense, I will be required to pay back the amount of the expense when requested by American Fidelity, by either check, credit card, or money order.
- I am authorizing that an additional Benefits Debit Card be issued in my dependent's name which will be used in conjunction with my Healthcare Flexible Spending Account offered by my employer. Dependents that have the additional Benefits Debit Card will have access to my account information, including protected health information.
- If the expense is greater than the amount available on the card, the card swipe will be denied.

REQUIRED SIGNATURE

Please complete and fax or mail to American Fidelity, at the address listed at the top of this form.

Employer Name: _____

Employee Name (please print): _____

Employee Social Security Number: _____

Employee Signature: _____ Date: _____