

**HEALTH SAVINGS ACCOUNT
Request for Additional/Replacement Debit Card**

Enter the information via your keyboard, print the form, sign it and fax it to the number above.

PLEASE NOTE: Do not use a coversheet if faxed. Fax will go into secured inbox. Bar code must be visible on first page for processing.

A. Account Holder's Information			
Name		SSN	
Address		DOB <small>(mm/dd/yyyy)</small>	
City, State, Zip		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Email address		Day Phone	

B. Replacement Card	
Name on card being replaced:	
Please select one of the following reasons for replacement card: <input type="checkbox"/> Lost/Stolen <input type="checkbox"/> Damaged <input type="checkbox"/> Other	
Comments	

*If your card is lost or stolen, please check your transactions for any suspicious activity. Contact us immediately at (800) 662-1113 if there are transactions on your account that you haven't authorized.

C. Additional Card Holder Information			
Name		SSN	
Relationship		*DOB <small>(mm/dd/yyyy)</small>	
Name		SSN	
Relationship		*DOB <small>(mm/dd/yyyy)</small>	
Name		SSN	
Relationship		*DOB <small>(mm/dd/yyyy)</small>	

*Additional card holder must be 18 years or older.

Account Holder's Signature

Date

