AMERICAN FIDELITY
a different opinion

Reimbursement Services | P.O. Box 25523 | Oklahoma City, OK 73125
American Fidelity Assurance Company | 800-662-1113 | Fax: 844-319-3668 | **americanfidelity.com**

Benefits Debit Card Request Form

Replacement Benefits Debit Cards

Reimbursement Account Type: ☐ Healthcare Flexible Spending Account (HCFSA) ☐ Limited Purpose Flexible Spending Account (LPFSA) ☐ Health Savings Account (HSA) ☐ Health Reimbursement Arrangement (HRA)

Full name on the card being replaced:

Please select one of the following reasons for replacement card: ☐ Lost/Stolen ☐ Damaged ☐ Other

Comments:

Request for Additional Benefits Debit Cards

☐ Please issue an additional Benefits Debit Card for my spouse and/or eligible dependents. For dependent children, a card will only be issued for those aged 18 to 26. ***Important: All fields are required. If any information is missing, the request cannot be processed.***

First and Last Name:	Social Security Number:	Date of Birth: (MM/DD/YYYY)	Relationship:
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Benefits Debit Card Rules of Participation

I understand the following guidelines:

- The Benefits Debit Card can only be used at qualified medical providers.
- I must keep all receipts/documentation and provide them to American Fidelity when requested.
- Failure to promptly respond to American Fidelity's request for documentation will result in my Benefits Debit Card being inactivated. I must repay the expense by check, credit card, or money order.
- If the medical provider doesn't accept the Benefits Debit Card, I must pay the expense and then submit the claim for reimbursement to American Fidelity through my online account or AFmobile.
- If I use the card to pay for an ineligible expense, I must repay the amount when requested by American Fidelity using a check, credit card, or money order.
- By authorizing an additional Benefits Debit Card to be issued in my dependent's name, my dependents will have access to my account information, including protected health information.
- The card swipe will be denied if the expense exceeds the available card balance.

Required Signature

Please complete this form and mail to: American Fidelity, P.O. Box 161968 Altamonte Springs, FL 32716 or fax to 844-319-3668.

Employer Name: _____

Accountholder Name (please print): _____

Accountholder Social Security Number: _____

Accountholder Signature: _____ Date: _____