Interactive Medical Systems

Benefits
Dependent Card Request

EMPLOYEE PROFILE

Employee Name: _____   Social Security #: _____

Address:
Street: _____   City: _____

State: _____   Zip: _____

DEPENDENT CARD

I would like a dependent card   ☐ **Yes** ☐ **No**   My dependent has a card. I would like to link it to the new plan year account.   ☐ **Yes** ☐ **No**

Dependent Name: _____   Relationship: _____ (Required)

Dependent DOB: _____ (Required)   Social Security #: _____ (Required)

Address:
Street: _____   City: _____

State: _____   Zip: _____

AUTHORIZATION

My Employer's benefits have been explained to me and I understand that I authorize the issue of a MasterCard Debit Benefits Card to the dependent listed above. I understand that this card will be linked to my Flexible Spending Account and/or HRA or HSA and that it is to be used for IRS allowable expenses, which are not reimbursable under any other plan.

Employee Signature _____   Date _____

Company Name _____   Group Number _____

PO BOX 1349   WAKE FOREST, NC 27588
ATTN: CONSUMER ACCOUNTS DEPARTMENT
PHONE: 919-877-9933 EXT 5052   FAX: 919-562-0021