



Benefits Card Additional Card Request

Employee Information (All Fields Required. If more than 2 cards are needed, please complete additional form(s) as needed.)

Employee Last Name	First Name	Middle Init.	Account ID (10 digits) or SSN
Employer Name			Daytime Phone Number () -

First Additional Dependent/Spouse FSA Benefits Card User Information

Last Name	First Name	Middle Initial	Social Security Number - -
Relationship to Employee (Please check one box) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent 18 years of age or older			Date of Birth / /
Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I certify that I will use the FSA Benefits Card that I will receive only for eligible medical care expenses under the Health Care Flexible Spending Account Plan of my spouse or the taxpayer claiming me as a dependent, and as defined in Section 213 of the Internal Revenue Code. I further certify that I will not seek reimbursement from any other plan for any medical expense paid with the FSA Benefits Card, nor will I claim any federal income tax deduction or credit with respect to such medical expense.			
Dependent/Spouse Signature X _____			Date _____

Second Additional Dependent/Spouse FSA Benefits Card User Information

Last Name	First Name	Middle Initial	Social Security Number - -
Relationship to Employee (Please check one box) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent 18 years of age or older			Date of Birth / /
Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I certify that I will use the FSA Benefits Card that I will receive only for eligible medical care expenses under the Health Care Flexible Spending Account Plan of my spouse or the taxpayer claiming me as a dependent, and as defined in Section 213 of the Internal Revenue Code. I further certify that I will not seek reimbursement from any other plan for any medical expense paid with the FSA Benefits Card, nor will I claim any federal income tax deduction or credit with respect to such medical expense.			
Dependent/Spouse Signature X _____			Date _____

Employee Authorization

I certify that my spouse/tax dependent will only use the FSA Benefits Card that he/she will receive in connection with my Employer's Health Care Flexible Spending Account Plan for eligible medical care expenses, as defined in the Health Care Flexible Spending Account Plan and in Section 213 of the Internal Revenue Code. I further certify that he/she will not seek reimbursement from any other plan for any medical expense paid with the FSA Benefits Card, nor will I claim any federal income tax deduction or credit with respect to such medical expense.	
I acknowledge that the initial card for each dependent will be provided at no charge. I acknowledge that any request to replace a previously issued card will result in my being charged a \$10.00 fee for each card replaced. This fee will automatically be deducted from my Flexible Spending Account balance.	
Employee Signature X _____	Date _____

Please return completed form to Ceridian via fax at 866-377-4261.

You may also mail to: **Ceridian, P.O. Box 534321, St. Petersburg, FL 33747.**

If for any reason an additional card cannot be issued, a Ceridian Representative will contact you.