





# 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 Initial	Social Security Number - -
Employer Name	Client Code	Daytime Phone Number ( )	

## First Additional FSA Card User Information

Last Name	First Name	Middle Initial	Social Security Number - -
Relationship to Employee (check one box) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent or Adult Child 18 years of age or older			Date of Birth / /
I agree to use the FSA Benefits Card only for eligible medical care expenses under the Health Care Flexible Spending Account Plan of the Employee listed above and as defined in Section 213(d) 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.			
First Additional User Signature <b>X</b> _____			Date _____

## Second Additional FSA Card User Information

Last Name	First Name	Middle Initial	Social Security Number - -
Relationship to Employee (check one box) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent or Adult Child 18 years of age or older			Date of Birth / /
I agree to use the FSA Benefits Card only for eligible medical care expenses under the Health Care Flexible Spending Account Plan of the Employee listed above and as defined in Section 213(d) 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.			
Second Additional User Signature <b>X</b> _____			Date _____

## Employee Authorization

I agree to ensure that each Additional User identified above will use the FSA Benefits Card only in connection with my employer's Health Care Flexible Spending Account Plan (the "Plan") for eligible medical care expenses, as defined in the Plan and in Section 213(d) of the Internal Revenue Code. I certify that each Additional User qualifies as either my spouse (as defined by Federal laws), dependent or adult child (as defined by the Plan) that is 18 years of age or older. I further certify that neither I, nor any Additional User, shall seek reimbursement from any other plan for any medical expense paid with the FSA Benefits Card, nor claim any federal income tax deduction or credit with respect to such medical expense.	
Employee Signature <b>X</b> _____	Date _____

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

You may also mail to: **Ceridian, P.O. Box 534200, St. Petersburg, FL 33747.**

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

RBA1911

## Direct Deposit Authorization

### Flexible Spending Account

Please attach a voided check or Savings Account Direct Deposit Form here.

### Instructions

**This form should be completed by FSA Participants upon initial enrollment of the benefit and need not be resubmitted each new plan period. You should remit this form if you have new or updated banking information to provide.**

- Please print all information legibly.
- Attach a voided check if you designate a checking account. Do not submit a deposit slip. If you designate a savings account attach a completed Savings Account Direct Deposit Form from your financial institution.
- Please sign and date the form. Omission of signature will delay processing.
- Mail completed form to the address indicated at the bottom of the page.
- Notify Ceridian immediately of any account changes or account closings.

Direct Deposit authorization requires that all account and bank routing numbers be verified for accuracy before any funds are transferred. Eligible claims submitted during the 10-day verification period will be reimbursed with a check. After the verification period, reimbursements will be posted to your bank account two to four days after the scheduled reimbursement date. You will receive a Reimbursement Statement through the mail. Always verify your statement to make sure it is not a negotiable check.

### Participant Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Daytime Telephone (\_\_\_\_\_) \_\_\_\_\_  
Employer Name \_\_\_\_\_ Client Code \_\_\_\_\_

### Bank Information

Check only one:  Set up Direct Deposit for:  
 Checking (please attach void check above)  
 Savings (please attach a Savings Account Direct Deposit Form from your financial institution)  
 Change Account Information  
 Cancel Direct Deposit

Full Bank Name \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Bank Routing Number (9-digit number on lower left of check) | | | | | | | | | |

Bank Account Number (to 17-digits) | | | | | | | | | | | | | | | | | |

### Important

- The designated account must be in your name.
- Processing of your Direct Deposit information will be delayed if you do not include both the bank account number and the bank routing number. Contact your bank if you are unsure of your bank account information.

### Authorization

I hereby authorize Ceridian to initiate credit entries for depositing my Flexible Spending Account reimbursements into my account designated above and, if necessary, make corrections for any entries made to my account in error. This authority is to remain in full force and effect until Ceridian has received written notification from me of its termination in such time and in such manner as to afford Ceridian a reasonable opportunity to act on it.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

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You may also mail to: Ceridian, P.O. Box 534200, St. Petersburg, FL 33747.