

Health Savings Account Additional Debit Card Request Form

Use this form to request an additional debit card for your spouse or any dependents.

1. Complete all sections of this form.
2. Email, mail, or fax completed form to:
 Email: CSR@proflextpa.com
 Address: Pro-Flex Administrators, LLC, 8321 Main Street, Williamsville, NY 14221
 Fax: 716-929-2013

*Required Fields

| Part I Consumer Information | | | | |
|------------------------------------|-------------------------|---|------|--|
| *Consumer Name (First, MI, Last) | | *Employer Name (If sponsored by an employer plan) | | |
| *Birth Date (MM/DD/YYYY) | *Social Security Number | *Day Telephone | | |
| *Address | *City | *State | *Zip | |

| Part II Additional Card Information | | | | |
|---|-------|--------|---------------------------|--|
| Please complete the following information for each additional debit card requested. | | | | |
| * Spouse Name (First, MI, Last) | | | | |
| * Spouse Name (First, MI, Last) | | | * Birth Date (MM/DD/YYYY) | |
| *Address | *City | *State | *Zip | |
| * Dependent Name (First, MI, Last) | | | | |
| * Dependent Name (First, MI, Last) | | | * Birth Date (MM/DD/YYYY) | |
| *Address | *City | *State | *Zip | |
| * Dependent Name (First, MI, Last) | | | | |
| * Dependent Name (First, MI, Last) | | | * Birth Date (MM/DD/YYYY) | |
| *Address | *City | *State | *Zip | |

| Part III Consumer Consent | |
|---|-------|
| I hereby give the information provided on this form is accurate. I understand that I am only able to request cards for dependents that are dependent to me as defined by IRC, and over the age of 18. I acknowledge that this form may be electronically signed, and I agree that the electronic signature appearing on this document is the same as my handwritten signature for the purpose of validity, enforceability, and admissibility. | |
| *Consumer Signature | *Date |