

**MISSISSIPPI STATE UNIVERSITY
MEDIFLEX Flexible Spending Account Program**

Pharmacy Debit Card Enrollment/Cancellation Form

Name:
MSU ID Number:
Mailing Address:
City, State, Zip Code:

The *take care*® Visa® pharmacy debit card contains the value of your annual Mediflex Flexible Spending Account election and lets you pay for qualified prescription and over-the-counter expenses at the point of service. Simply swipe the *take care*® card at participating retailers that accept Visa and the amount of your purchases will be deducted from your flexible spending account automatically.

Check one of the following boxes to either request the *take care*® Pharmacy Debit Card or cancel your enrollment in the Pharmacy Debit Card program.

- I request a *take care*® Pharmacy Debit Card for qualifying prescription and over-the-counter expenses and understand that the cost will be \$1.00 per month which will be deducted from my payroll check.

- I would like to cancel my participation in the Pharmacy Debit Card program.

As a new *take care*® pharmacy debit card participant, by signing this form and using the *take care*® card for qualified prescription and over-the-counter expenses for the Plan Year, **I understand, certify and agree that:**

- Use of the *take care*® card is limited to eligible prescription and over-the-counter expenses up to the maximum dollar amount of coverage available in my Mediflex Flexible Spending Account;
- I will not seek reimbursement of any expenses paid with the *take care*® card under any other plan covering health benefits;
- I understand that I will continue to submit claims for other medical expenses such as doctor's office or hospital visits, dental and vision expenses;
- I agree to read and adhere to the cardholder statement provisions, which I will receive with the card and understand the card may be deactivated if I do not comply with those provisions;
- I understand that my card will be deactivated if I end employment or am no longer enrolled in the Mediflex Flexible Spending Account;
- I also understand that each time I use the *take care*® card, I recertify my understanding and agreement to the above terms; and
- **I am responsible for saving expense receipts and documentation for all *take care*® card uses.**

Signature: _____

Date: _____

Pharmacy Debit Card Enrollment Forms should be sent to: Department of Human Resources Management Box 9603 Mississippi State, Mississippi 39762 or Mail Stop 9603 Telephone: (662) 325-3713 - Fax: (662) 325-0753
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