



**SABC FLEXCard Application**  
Debit Card by Evolution 1

1. <b>EMPLOYER NAME</b>	2. <b>DATE OF BIRTH</b>
3. <b>EMPLOYEE NAME (First, Last)</b>	4. <b>SOCIAL SECURITY #</b>
6. <b>EMPLOYEE MAILING ADDRESS (Street or Box)</b>	5. <b>EMPLOYEE #</b>
	7. <b>CITY, STATE and ZIP</b>
8. <b>EMAIL ADDRESS</b>	9. <b>DAYTIME PHONE #</b>

I understand:

I will receive (2) SABC FLEXCards, at no charge. If I would like to order any additional cards, or should I lose my card and require a replacement, I understand the fee is \$10.00, and it will be deducted from my eligible medical expense balance.

I am requesting a debit card to be used in conjunction with my Unreimbursed Medical spending account, for eligible medical expenses (*as outlined by my employers' Cafeteria Plan Document*). I understand that I may only use the card to pay for qualified medical expenses for myself, and/or my spouse and/or eligible dependents. I will not use the card for any medical expenses that have already been reimbursed, or are reimbursable under any other health plan coverage, and will not be claimed as an income tax deduction; I am to acquire and retain sufficient documentation, including invoices and/or receipts, for expenses paid with the card, including my Explanation of Benefits "EOB" from my insurance provider. I also understand that should I use the card for any expense that is deemed an overpayment, (*after my insurance has been applied*), I will be responsible for returning the overpayment portion to my plan, and possibly any documentation needed when notified. I understand should I delay beyond the time frame allowed to return the requested documentation and/or overpayment, my flex card will be suspended.

My employer may require that I pay the cost of the card (check with your Human Resource Dept), if required the per pay period cost will be deducted tax free from my paycheck. My card is valid for (3) to (5) years (check card expiration date upon receipt) and will be funded each year unless I cancel the card, terminate employment or cease to be a participant in Unreimbursed Medical. Should I reelect to participate within the (3) to (5) year period with the same employer, I understand that my card will be reactivated. Should I lose or destroy my card, the \$10.00 replacement fee would apply.

I have been explained and understand the terms and conditions of the card. If I should terminate my employment, I understand that my card will no longer be valid and I must submit future claims to Southern Administrators and Benefit Consultants, Inc., (SABC) for reimbursement. I understand and agree to follow the rules as stated and I reaffirm these terms each time the card is used.

Turn signed form into your Human Resource office

<b>EMPLOYEE SIGNATURE</b>	<b>DATE</b>

## SABC Flexcard Application Instructions

- Enter employer name
- Enter your date of birth
- Enter your name: first, last
- Enter your social security number
- Enter your employee Id number
- Enter your mailing address
- Enter your city, state and zip code
- Enter your email address
- Enter your daytime phone number
- Sign your application
- Enter the date

Please send the completed form to the Human Resource Department via:

- In person: 245 Barr Ave, 150 McArthur Hall
- U. S. Mail: PO Box 9603, Mississippi State, Ms 39762
- Fax: 662 325-0753
- Secure e-mail: contact your benefit specialist listed on the website: [hrm.msstate.edu](http://hrm.msstate.edu) for information how to send secure email. To find your benefit specialist, view the home page, about us, our staff.
- Campus mailstop 9603
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