SABC FLEXCARD ENROLLMENT FORM

Application for an SABC FlexCard, to be used in conjunction with the Unreimbursed Medical spending account.

1. EMPLOYER NAME	2. DATE OF BIRTH
3. EMPLOYEE NAME (First, Last)	4. SOCIAL SECURITY
5. EMPLOYEE MAILING ADDRESS (STREET OR BOX, CITY, STATE, ZIP)	6. DAYTIME PHONE
7. EMAIL ADDRESS	8. EVENING PHONE

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 dependents. I will not use the card for any medical expenses that have already been reimbursed; I certify that these expenses(s) have not been previously reimbursed and are not 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 (*if requested*) an 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 may be cut off.

I understand that a fee of $1.10 per ,month will be deducted, tax free from my paycheck, to cover the cost of the card. My card is valid for (5) years 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 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.

EMPLOYEE SIGNATURE **DATE**