



ENROLLMENT/CHANGE FORM
Health Reimbursement Accounts
with
Beniversal® MasterCard®
(PLEASE PRINT CLEARLY)

plans that perform
 2320 Brighton-Henrietta Townline Rd
 Rochester, NY 14623
 Phone: 1-800-473-9595
 Website: www.BenefitResource.com

EMPLOYER:

A. EMPLOYEE INFORMATION

Member ID: _____

Employee Name: (Last) _____ (First) _____ (MI) _____

Home Address: (Street) _____ Apt # _____

(City) _____ (State) _____ (Zip Code) _____

Home Phone #: _____ Birth Date: / / Gender: Male Female

Hire Date: / / Employee Status: Full-Time Part-Time

E-mail Address: _____

(Note: Benefit Resource will only use your e-mail address to communicate with you regarding your Plan.)

The purpose of this agreement is to authorize the employer to provide the employee with selected benefits. This agreement is designed to conform with Section 105(h) of the Internal Revenue Code.

B. BENIVERSAL CARD - SAVE ALL RECEIPTS! This section must be completed (please check only one box).

Employer use only

Please send me a Beniversal Card to use only for qualified medical expenses (I am not a current cardholder). **NOTE: Please provide E-mail address above.**

C

I will continue to use my current Beniversal Card as long as I am enrolled in the Plan.

Y

I am not a current cardholder and do not want a Beniversal Card issued to me.

N

C. EMPLOYEE CERTIFICATION

I have received and read the printed material which explains my Plan and my options under it. I understand that any expenses paid under this Plan must be eligible expenses as governed by IRS regulations, must be for services provided for me or a qualifying individual and must not be reimbursed from any other source.

I understand that Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. I also understand that I may be required to provide identifying information (e.g. social security number, address and date of birth) when making inquiries about my account. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.

If I receive a Beniversal MasterCard issued by a bank chosen by Benefit Resource:

- I agree to use this card only for eligible medical expenses under the Plan for me or a qualifying individual and to be bound by all provisions of the Beniversal Cardholder Agreement and My Beniversal Use of Card Promises sent to me with my card. Furthermore, I understand that if my Beniversal Card is used for expenses other than eligible medical expenses or if I violate the terms of the Agreement, I may lose Beniversal Card privileges and will reimburse the Plan for the expenses. I authorize my employer to deduct any non-approved expense directly from my paycheck on an after-tax basis. I also authorize expenses for replacement cards and paper follow-up requests to be deducted from my account balance as needed.
- Since the IRS requires that certain purchases made with the Beniversal Card be verified for eligibility, I agree to acquire and retain sufficient documentation for any expense paid with the card and to submit such follow-up documentation to Benefit Resource upon request.

Signature: _____ Date: ____ / ____ / ____

D. EMPLOYER SECTION (to be completed by the employer)

• Effective date of enrollment/change: ____ / ____ / ____

• **Please select only one option:**

New Enrollment: funding amount _____ per Plan Year other _____

Termination Resignation Retirement Change in hours Other _____

• **Health Insurance Coverage Code:** ____ ____ ____ ____ ____ ____ *(This six digit code can be obtained from your Group Insurance Information form.) Note: If employee is not insured through employer sponsored insurance plans, enter NOMED.*

Please return completed form to your employer.

The Employer maintains a Plan Document; if anything in this document conflicts with the Plan Document, then the Plan Document controls.