ENROLLMENT/CHANGE FORM

Health Reimbursement Accounts with Beniversal® MasterCard®

(PLEASE PRINT CLEARLY)

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

EMPLOYER:

A. EMPLOYEE INFORMATION

Member ID *(typically your SSN)*:

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

Home Address: (Street) Apt #

(City) (State) (Zip Code)

Home Phone #: E-mail Address:

Hire Date: / / Birth Date: / / Gender: ☐ Male ☐ Female

Employee Status: ☐ Full-Time ☐ Part-Time

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: You must provide E-mail address above to receive a card***.	C
☐ I DO NOT want a Beniversal Card (I am not a current cardholder)	N
☐ I will continue to use my current Beniversal Card through the expiration date on the card as long as I am enrolled in the Plan.	Y
☐ Cancel my current Beniversal Card. I understand the card can no longer be used and should be destroyed by me.	X

C. 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 Carrier: ____

Health Insurance Plan Name: ____

Note: If Employee is not insured through your Plan(s), enter ***No Coverage****.*

D. 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.
- If elected, I authorize the issuance of a Beniversal® MasterCard® by a bank chosen by Benefit Resource. I agree to use this card only for eligible Plan expenses for me or a qualifying individual and to be bound by all provisions of the Beniversal *Cardholder Agreement* and *My Use of Card Promises* sent to me with my card. Furthermore, I understand that if my Beniversal card is used for expenses other than those eligible for reimbursement under the Plan 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 replacement card expenses to be deducted from my account balance.
- 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 Beniversal card. I understand that any personal information obtained will not be shared with anyone, including non-affiliated third parties, except as permitted by law.
- Since the IRS requires substantiation for certain purchases made with the Beniversal card, I agree to acquire and retain sufficient documentation for any expense paid with the card.

Signature: ____ Date: _____ / _____ / _____

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.