HealthNow Administrative Services

Debit Card Authorization

Employee Information		
Last Name	First Name	M.I.

Employer Name	Date of Birth

Home Address

☐ I elect to use the debit card associated with the benefit account(s) made available to me through my employer and acknowledge my understanding that:

- This debit card is intended only for, and restricted to, use for eligible services and/or purchases associated with my employer's benefit account(s), as governed by the Internal Revenue Service and/or all federal and relevant state laws.
- I am responsible to save receipts related to any debit card transactions and must present receipts to the plan upon request.
- Any expenses for which I use the debit card have not been reimbursed and will not be reimbursed by another health plan.
- I must refund the amount of any expense deemed ineligible under my benefit account.

☐ I waive participation in the debit card program.

Spouse/Dependent Child(ren) Debit Card
Dependent child(ren) must be over 18 years old to be eligible to receive a debit card.

☐ Yes, I request a debit card for my legal spouse and/or dependent child(ren) named below and understand that the above provisions apply to the use of that card.

Spouse or Child?	Last Name	First Name	Social Security Number	Date of Birth

Employee Signature	**Date**

Please send form using the information provided below:

HealthNow Administrative Services P.O. Box 742 Blue Bell, PA 19422
Tel 800-518-8332 Fax 855-226-0680
E-mail hnas.flexteam@hnas.com