

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) Debit Card Authorization

EMPLOYER INFORMATION

Employer Name

EMPLOYEE INFORMATION

Last Name	First Name	M.I.
Social Security Number	Date of Birth	
Home Address		

I have been given the opportunity to participate in the HRA debit card. I acknowledge my understanding that:

- This debit card is intended only for, and restricted to, use for eligible services and/or purchases associated with my HRA, as governed by the Internal Revenue Service and/or all relevant federal and state laws.
- I must refund the amount of any expense deemed ineligible under my HRA.
- I must sign the back of my card before using it.
- I must report a lost or stolen debit card.
- I am responsible to save all receipts and present said receipts upon request.
- All provisions apply to my spouse's use of the debit card.

SPOUSE INFORMATION

Yes, I request a debit card for my Legal Spouse/dependent child, and understand that the above provisions apply to the use of that card.

Last Name	First Name	M.I.
Social Security Number	Date of Birth	

EMPLOYEE SIGNATURE

Date

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