CareFirst BlueChoice

CareFirst BlueCross BlueShield

Additional Flex Debit Card Request

Company Name	Employee Name	SS Number (last 4 digits only)

E-mail Address	Eligible Spouse/Dependent's Name

Address: (please provide update if changed)

Notice

One (1) additional debit card will be issued at no further cost. However, requests of more then one (1) additional debit card, will incur a charge of $5.00 per card. These additional requests **must** be mailed along with a check made payable to: PayFlex Systems USA, Inc. All dependents must be 18 years or older to receive a card.

Mail to:
CareFirst Debit Addition
13511 Label Lane Suite 201 Hagerstown, MD 21740

Fax to:
(301) 530-4161

Checks made payable to (if applicable):
PayFlex Systems, USA Inc.

Debit Card Agreement Summary

I agree to maintain any of the following documentation that may include: copies of all receipts, billing statements and/or Explanation of Benefits (EOB). All documentation should be kept with my tax return(s) for seven (7) years.

Debit card(s) should only be used for eligible healthcare products and/or services as outlined by the Internal Revenue Service (IRS) or by my employer. Transactions that are more then my available balance will be denied. I am responsible for reading the card holder agreement that I will receive with the debit card in the mail and understand that the above is only a summary.

I agree to abide by the terms and agreements set forth above for both myself & my dependent(s):

Employee Signature: _____ __ Date: _____

Revised 06/29/2012