



FLEXIBLE SPENDING ACCOUNT CARD REQUEST FORM (FSA)

EMPLOYEE INFORMATION

Employer: University Medical Center of El Paso ☐ El Paso Children's Hospital ☐

Member Last Name: _____ Member First Name: _____

Social Security Number: _____ Daytime Phone Number: _____

Address: _____ Email Address: _____

REASON FOR FSA CARD REQUEST

STOLEN CARD: ☐ LOST CARD: ☐ DESTROYED CARD: ☐

DEPENDENT CARD REQUEST: ☐ SPOUSE CARD REQUEST: ☐

If you are requesting a card for your dependent/spouse, please fill out the section below. Please list an eligible dependent or legal spouse, as defined by IRS Code 152, to whom the Benefit Card should be issued. **If you need additional cards for each dependent, please fill a separate form for each dependent.**

Last Name of Dependent/Spouse: _____ First Name of Dependent/Spouse: _____

DOB: _____ SSN: _____

Address: _____

Apt: _____

City: _____ State: _____ Zip Code: _____

EMPLOYEE AUTHORIZATION

By providing dependent/spousal information and signing the *FSA Card Request Form*, I authorize and understand that one additional Benefit Card will be issued under the FSA System. A card will only be issued to a legal spouse as defined by IRS Code 152. Use of card will directly affect my account balance. I am fully responsible to ensure that my spouse/dependent complies with the rules and regulations regarding the use of the card as outlined in the cardholder agreement to which I agree to be bound.

Signature _____ Date: _____

Mail to:
Preferred Administrators
1145 Westmoreland Drive
El Paso, TX 79925
Phone: 915-532-3778
Fax to: 915-225-1174
Email: fsapreferredadmin@elpasohealth.com