Stewart's Shops

FOR OFFICE USE ONLY:
DATE OF HIRE: _____
DISTRICT# _____
SHOP/DEPT # _____

Request for Additional Medical Reimbursement Debit Card(s)

Last Name	First Name	M.I.	Social Security Number	Date of Birth
Mailing Address: Street		City	State	Zip

Additional Card(s) requested for (must be spouse or dependent 18 years or older):

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

I acknowledge that I am requesting this Debit Card for my legal tax dependent. It is my understanding that:

In conjunction with the health FSA and the HRA, Stewart's Shops permits electronic reimbursement of medical expenses through the use of a debit card or stored-value card ("card"). Under the arrangement adopted by Stewart's Shops, each participating employee is issued a card and certifies upon enrollment in the health FSA and HRA and each plan year thereafter that the card will only be used for eligible medical care expenses, as defined in §213(d), of the employee and the employee's spouse and dependents. The employee also certifies that any expense paid with the card has not been reimbursed and that the employee will not seek reimbursement under any other plan covering health benefits. An employee-cardholder understands that the certification, which is printed on the back of the card, is reaffirmed each time the card is used. The cardholder also agrees to acquire and retain sufficient documentation for any expense paid with the card, including invoices and receipts where appropriate. The card is automatically cancelled at termination of employment.

Employee Signature _____ Date _____