



**HEALTH SAVINGS ACCOUNT  
Request for Additional/Replacement Debit Card**

Enter the information via your keyboard, print the form, sign it and fax it to the number above.

PLEASE NOTE: Do not use a coversheet if faxed. Fax will go into secured inbox. Bar code must be visible on first page for processing.

A. Account Holder's Information			
Name		SSN	
Address		DOB (mm/dd/yyyy)	
City, State, Zip		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Email address		Day Phone	

B. Replacement Card	
Name on card being replaced:	
Please select one of the following reasons for replacement card: <input type="checkbox"/> Lost/Stolen <input type="checkbox"/> Damaged <input type="checkbox"/> Other	
Comments	

\*If your card is lost or stolen, please check your transactions for any suspicious activity. Contact us immediately at 1-866-326-3600 if there are transactions on your account that you haven't authorized.

C. Additional Card Holder Information			
Name		SSN	
Relationship		*DOB (mm/dd/yyyy)	
Name		SSN	
Relationship		*DOB (mm/dd/yyyy)	
Name		SSN	
Relationship		*DOB (mm/dd/yyyy)	

\*Additional card holder must be 18 years or older.

**There is a \$10.00 fee for each additional debit card after the two initial cards. The fee will be automatically deducted from your health savings account. If there are not sufficient funds in your account, your request will not be processed until your next contribution is received.**

\_\_\_\_\_  
Account Holder's Signature

\_\_\_\_\_  
Date



##25T0093#####