



EMPLOYER FlexCard SETUP

**THIS FORM MUST BE COMPLETED AND ENTERED NO LATER THAN 30 DAYS PRIOR TO CARD
ISSUANCE DATE**

SECTION 1

EMPLOYER NAME	
ADDRESS	
PHONE	
WEBSITE	
PAYROLL/BUSINESS MGR. NAME	
PAYROLL/BUSINESS MGR. PHONE	
CARD TYPE:	RX only____ Open____
4TH LINE EMBOSSING (MAX 24 CHARACTERS)	
PLAN YEARS	1 ST YEAR 2 ND YEAR
PROGRAM TYPE	<input type="checkbox"/> FSA <input type="checkbox"/> HRA
BENNY CARD FEE	FEE AMOUNT: HOW IS IT BILLED <input type="checkbox"/> MONTHLY <input type="checkbox"/> YEARLY
TOTAL ELIGIBLE EMPLOYEES	
GRACE PERIOD _____	500 ROLLOVER_____

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SECTION 2

FOR OFFICE USE ONLY	
CLIENT ID:	
PROGRAM ID:	
NOTES:	

I understand that the debit card bank requires that 6% of all card holders' annual election, must remain in the account at all times during the year. I authorize SABC to fund this account with currently held supplement funds, but understand that additional funding may be necessary. If SABC does not currently hold supplemental funds, I will be notified of the amount I must fund, prior to the cards being issued.

PRINT NAME	TITLE
SIGNATURE	DATE