SABC FLEXCARD ENROLLMENT FORM

SECTION 1

1. COMPANY NAME	2. DATE OF BIRTH
3. EMPLOYEE NAME (First, Last)	4. SOCIAL SECURITY #
5. EMPLOYEE MAILING ADDRESS (STREET OR BOX, CITY, STATE, ZIP)	6. DAYTIME PHONE
7. EMAIL ADDRESS	8. EVENING PHONE

You will receive (2) cards, at no charge. If you would like to order additional cards, please complete the dependent information below. Each additional card is $10.00, and will be deducted from your eligible balance.

SECTION 2 (ONLY IF ORDERING ADDITIONAL CARDS AT $10.00 EACH) EMPLOYEES' NAME WILL APPEAR ON ALL CARDS.

DEPENDENT NAME	DEPENDENT NAME
DEPENDENT NAME	DEPENDENT NAME

I am requesting a debit card to be used for prescription and over-the-counter drugs in conjunction with my Unreimbursed Medical spending account. I understand that I can only use this card at participating merchants and retailers. I also understand that a fee of $_____per _____ will be deducted, tax free from my paycheck, to cover the cost of the card. My card is valid for (5) years and will remain in effect during that period, unless I cancel the card, terminate employment or cease to be a participant in Unreimbursed Medical.

I have been explained and I understand the terms and conditions of the card. If I should terminate my employment, I understand that my card will no longer be valid and I must submit future claims to SABC for reimbursement.

EMPLOYEE SIGNATURE	**DATE**