

ASIFlex FSA Debit Card Application

Please print all fields clearly to avoid spelling errors.



Employer		Social Security Number (must be included or no card will be issued)		
Last Name:		First Name, Middle Initial		
Street Address:	City:	State:	Zip:	
Daytime Phone:	Home Phone:	Date of Birth: mmddyyyy (must be included or no card will be issued)		
Email Address (must be included or no card will be issued)		Employee Identification Number (if available)		

- ✓ The debit card is optional.
- ✓ If you do want a card, you have to complete this application. If you do not apply for the card, you will file claims and ASIFlex will reimburse you by direct deposit or check.
- ✓ Two debit cards, both in the name of the actual FSA participant, will be issued from an approved application. The card provider mails these cards directly to you approximately 10-14 business days from ASIFlex's processing of the application. There is a \$5.00 charge for additional or replacement cards.
- ✓ Please note that as mentioned on the reverse side of this application, **you will be required to submit substantiating documentation for some debit card transactions.** ASIFlex will notify you when follow-up documentation is required; **until you receive this notification, please do not submit support for these items.**
- ✓ **Always select the "credit" option when you present the card** at a merchant or a provider, even though the card is referred to as a "debit card." There is no PIN number associated with this FSA debit card.
- ✓ **There is an additional fee for the card of \$12.00/year.** This fee will be deducted from the your FSA balance on the first pay period of the month in which the card is requested.

I hereby state that the above information is accurate, to the best of my knowledge. Additionally, I certify that the FSA debit card will only be used to purchase eligible medical care expenses, as defined in Code §213(d) of the Internal Revenue Code and that I will not seek reimbursement from any other source for the expenses paid for with the FSA debit card.

Participant's Signature:

Date:

The application must be sent directly to ASI. Please fax application, toll-free,
to: 1-877-879-9038 or
Mail to: ASI, P O Box 6044, Columbia, MO 65205-6044