********An Email Address is REQUIRED for a debit card********

***my*SourceCard™ Enrollment Agreement for:**

EMPLOYER NAME: _____

As a participant in one or more of your Employer FSA Plans you will receive a *my*SourceCard™ MasterCard® Debit Card issued by Benefit Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used ***exclusively*** for Qualified Expenses as defined by the plan(s) in which you participate. If the Card is issued pursuant to Employer Plans and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all invoices and receipts related to any expense paid with the Card; upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

For proper Cardholder Identification, please complete the following information. Your Card will not be issued until Flex Administrators, Inc receives this form.

ALL FIELDS ARE REQUIRED *(Please print clearly)*

Name on Card: (Please Print)_____
21 characters maximum including spaces

Medical Plan (Choose One) ☐ I am currently on my Employer's Medical Plan ☐ I am not on my Employer's Medical Plan

Mother's Maiden Name (Security purposes only): _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Home Phone: _____

E-mail Address: _____

Please Print Clearly

Name on 2nd Card: (Please Print) _____ 3rd Card (Please Print)_____
21 characters maximum including spaces *21 characters maximum including spaces*

Signature: _____ Date: _____

For Official Use Only

Flex Administrators, Inc. Processed Date: _____/_____/_____

Per Card Fee: $_____

Revised 10.2.8

Remit to: Flex Administrators, Inc.
Fax: 616-454-6090 or 616-454-9862