



# Secondary Benefits Card Authorization

Fax to: **608 831 4790**  
 Mail to: **Employee Benefits Corporation, PO Box 44347, Madison WI 53744-4347**  
 Phone support: **800 346 2126 | 608 831 8445**  
 E-mail support: **participantservices@ebcflex.com**

## Account Holder Information

**Last 4 Digits of Social Security or Identification Number**  
(Required)

Last Name

First Name

E-mail Address (we do not share your e-mail address)

Employer Name

## Add/Edit/Terminate a Secondary Benefits Cardholder

Secondary Cardholder Name

Relationship

Add

(Selecting "Add" means you authorize this person to receive a Benefits Card for your Plan in the name of the cardholder. Only one additional Benefits Card may be activated for the Plan.)

Edit

(You may edit the first and/or last name of an existing secondary benefits cardholder. Please enter the name above.)

Terminate

(The termination date will be the date the form is processed)

## Account Holder Certification

A debit card has been provided to me. I certify the use of the Benefits Card is only for payment of eligible expenses under the Plan and any expense paid with the Benefits Card will not be reimbursed, nor will I seek reimbursement under another Plan. I agree to provide substantiation to prove any expense reimbursed is eligible under the Plan, and to reimburse the Plan in cases where I have been reimbursed in error for an expense ineligible under the Plan. These terms also apply to the second authorized card.

Account Holder Signature

Date (mm-dd-yyyy)