

**PLANO INDEPENDENT SCHOOL DISTRICT
FLEXIBLE BENEFIT PLAN
JANUARY 1, 2010 – AUGUST 31, 2010**

NAME: _____

SSN: _____

REQUEST FOR AN ADDITIONAL BENEFITS CARD

Benefits Card Certification

I acknowledge that I will agree to the terms and conditions of the Cardholder Agreement received with my Benefits Card and certify that I will only use the card for qualified health care and/or dependent care expenses. I further certify that I will not seek reimbursement under any other health plan coverage for claims that have been paid for by the card, nor will I use the card for expenses that have been paid by any other health plan benefit. I acknowledge that I will, upon request of the plan administrator, provide required documentation of expenses.

- I would like to have a second card issued to my dependent, whose name and social security number are indicated below.

Dependent Name

Dependent Social Security Number

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (CREDITS)

I hereby authorize **PLANO INDEPENDENT SCHOOL DISTRICT**, hereinafter called **EMPLOYER**, to initiate credit entries to my

_____ checking savings account
(name of bank)

indicated below and the depository named below, hereinafter called **DEPOSITORY**, to credit the same to such account. I also authorize the **EMPLOYER** to draw drafts on my account or to initiate debit entries to my account, for the purpose of withdrawing money from my account, but solely in order to adjust an error resulting from a deposit or credit entry that has been made under this Authorization in an amount that is not correct. The **DEPOSITORY** shall not be liable for honoring any draft, debit entry or withdrawal initiated by the **EMPLOYER**.

Depository Name (Account Holder's Name):	Office: N/A (leave blank)
Bank Transit/ABA Number (9-digit routing number):	Account Number:

This authority is to remain in full force and effect until termination from the plan or notification in writing by the participant.

Date: _____ Signature: _____

NOTE: New accounts, please attach a voided check to this authorization agreement.

AUTHORIZATION FOR CLAIMS COMMUNICATION TO BE SENT VIA EMAIL

I authorize Flexible Benefit Administrators, Inc. to send me information regarding my claims via email. I understand that I will no longer receive claims communication via U.S. mail to my home address.

It is also my responsibility to notify Flexible Benefit Administrators, Inc. if this information should change or if I elect to stop correspondence via email.

EMPLOYEE NAME

EMAIL ADDRESS

HOME TELEPHONE NUMBER

SIGNATURE

Return this form to Flexible Benefit Administrators,
Email flexdivision@flex-admin.com or Fax 757-431-1155