Educators Benefit Consultants, LLC
Third Party Administrator

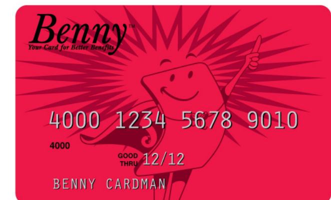
BENNY CARD ENROLLMENT FORM

Employer: ____
Name of Employer (not building you work in)

Name: ______________________________ SSN: _________________________

Yes, I want the *Benny™ Prepaid Benefits Card,* developed by Evolution Benefits to access my Medical FSA and/or Health Reimbursement Arrangement funds!

Please check all that apply:



- ☐ MEDICAL FSA
- ☐ HEALTH REIMBURSEMENT ARRANGEMENT

(If you have both accounts, funds will be "stacked" on one card)

I agree that $20.00 will be deducted from the appropriate account[1] every plan year to pay for two (2) *Benny™ Prepaid Benefits Card.*

I agree that if I wish to cancel the card I shall call EBC at 1-888-507-6053.

I agree to use the card to pay for Internal Revenue Code Section 213(d) medical expenses for myself, my spouse and/or legal dependent(s).

I will not use the card for any medical expense that already has been reimbursed.

I will not seek reimbursement under any other health plan for any expense paid for with the card.

I will acquire and retain sufficient documentation (including invoices and/or receipts) for any expense paid with the card.

_________________________________ _______________________
Signature Date

[1] Fee will be deducted from Medical FSA if you have Medical FSA and HRA.

3125 Airport Parkway, Cambridge, MN 55008
Metro: 763-552-6053 Toll Free: 888-507-6053 Fax: 763-552-6055
www.ebcsolutions.com