Benefit Advantage

DEBIT CARD APPLICATION

Both sides of this application must be fully completed before set-up of the card can be initiated
Funding information must be submitted with application. Send completed application with fee payable to:
Benefit Advantage, Attn: Finance, P.O. Box 5490, De Pere, WI 54115-5490

NOTE THE TIMELINE:

30 day Lead-Time for client set-up and another 30 days for cards to be issued after pre-fund is received

Employer Name**:** _____ Total # of EE's: _____
(Enter name **EXACTLY** as it appears on tax returns and is to appear in documents.)

Owner: _____ Main Contact: _____

Accts Payable Contact: _____ Title: _____

Address: _____

Phone # Fax # Email Tax ID#

Plan Year Information:

Initial Plan year: Effective Date _____/_____/_____ through _____/_____/_____

Subsequent plan years: Effective Date _____/_____ through _____/_____

Plans subject to debit card: ☐ Health FSA ☐ Limited Purpose FSA ☐ Dependent Care* ☐ HRA* ☐ Limited Purpose HRA ☐ Transportation ☐ HSA*

*Payment from the dependent care, HRA and HSA accounts will occur as the accounts are funded.

If an **HSA Plan** is selected it **will pay first**. If an FSA and HRA are selected, check which will pay first: ☐ Health FSA ☐ HRA

What Expenses are reimbursable: ☐ Medical ☐ Dental ☐ Vision ☐ RX/ Pharmacy ☐ Over-the-Counter items
Applies only to the HRA Plan Design

Does your plan include an additional grace period extension: ☐ Y ☐ N

If yes, funds will be pulled from the previous plan year first, if there is an available balance.

Program Funding Arrangements:

The Debit Card Programs must be pre-funded. 5% of the total annual election amount is required before cards can be issued.
ACH – Benefit Advantage initiates the transfer. Required Bank information for the ACH transfer:

Name of Banking Institution: _____

Routing#:_____(9 digits) Account#:_____

Authorized Signature: _____

If you have multiple Health Insurance Plans, please fill out a separate section below for each:

Health Insurance Plan #1 Health Insurance Company Name: _____Group#_____
Select a Pharmaceutical Benefit Manager (PBM) If no PBM check here☐

☐ Advance PCS ☐ Express Scripts ☐ Medimpact ☐ Caremark ☐ Medco Health
☐ Pharmacare ☐ Argus ☐ RX West ☐ Eckerd Health Systems (EHS)
☐ Other (specify): _____

Co-Pays - In order for the debit card to Auto Substantiate, co-pays **MUST** be listed, & must be whole dollar amount-NO percentages!

Medical	**Pharmacy**	**Pharmacy Mail Order**
Ambulance _____	Generic _____	Generic _____
Emergency Room _____	Brand Name _____	Brand Name _____
Hospital _____	Non-Formulary _____	Non-Formulary _____
Office Visit _____	Other _____	Other _____
Dental _____	Other _____	Other _____
Vision _____		
Other _____		

Health Insurance Plan #2 Health Insurance Company Name:_____Group#_____
Select a Pharmaceutical Benefit Manager (PBM) If no PBM check here ☐

☐ Advance PCS ☐ Express Scripts ☐ Medimpact ☐ Caremark ☐ Medco Health
☐ Pharmacare ☐ Argus ☐ RX West ☐ Eckerd Health Systems (EHS)
☐ Other (specify): _____

Co-Pays - In order for the debit card to Auto Substantiate, co-pays **MUST** be listed, & must be whole dollar amount-NO percentages!

Medical	**Pharmacy**	**Pharmacy Mail Order**
Ambulance _____	Generic _____	Generic _____
Emergency Room _____	Brand Name _____	Brand Name _____
Hospital _____	Non-Formulary _____	Non-Formulary _____
Office Visit _____	Other _____	Other _____
Dental _____	Other _____	Other _____
Vision _____		
Other _____		

Health Insurance Plan #3 Health Insurance Company Name:_____ Group#_____
Select a Pharmaceutical Benefit Manager (PBM) If no PBM check here ☐

☐ Advance PCS ☐ Express Scripts ☐ Medimpact ☐ Caremark ☐ Medco Health
☐ Pharmacare ☐ Argus ☐ RX West ☐ Eckerd Health Systems (EHS)
☐ Other (specify): _____

Co-Pays - In order for the debit card to Auto Substantiate, co-pays **MUST** be listed, & must be whole dollar amount-NO percentages!

Medical	**Pharmacy**	**Pharmacy Mail Order**
Ambulance _____	Generic _____	Generic _____
Emergency Room _____	Brand Name _____	Brand Name _____
Hospital _____	Non-Formulary _____	Non-Formulary _____
Office Visit _____	Other _____	Other _____
Dental _____	Other _____	Other _____
Vision _____		
Other _____		

Agent/Broker Name:_____

Phone:

BA Consultant: _____ **Customer #** _____ **Enrollment Fee:**_____ **Collected:** ☐ **Y or** ☐ **N**

Per Participant Fee: _____ Renewal Fee: _____

Benefit Advantage, Inc. sends to clients a Welcome Kit which includes verification of pricing and a standard service agreement. Please sign, date, and return. Failure to sign, date and return while accepting services will be viewed as acceptance of our standard business terms and conditions.