Educators Benefit Consultants, LLC
Third Party Administrator

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PREPAID BENEFIT CARD ENROLLMENT FORM

Employer: _____

Name: _____ **SSN:** _____

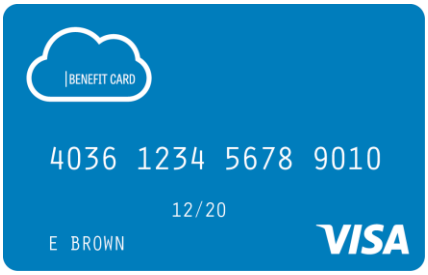
Yes, I want the *Prepaid Benefits Card,* developed by Evolution Benefits to access my Medical FSA and/or Health Reimbursement Arrangement funds!

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) *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