MyHSA Request for Additional Debit Cards

Instructions – This form is used to order additional debit cards for your MyHSA account.

As a MyHSA Health Savings Account participant, I understand that I will be provided with one Debit Card at no additional cost. I understand that as a MyHSA participant, I may request additional Debit Cards for my spouse and/or other adult dependent. I agree that any usage of a dependent Debit Card, requested and authorized by me as an HSA Account Holder, will result in a withdrawal of funds from my HSA Account and will be processed as if I (the HSA Account Holder) were initiating the transaction. Additional Debit Card requests will be processed and the Debit Card mailed to the address of the MyHSA Account Holder within ten business days following receipt of this authorization. I agree that my HSA account will be charged five dollars ($5.00) for each additional card requested.

MyHSA Account Holder Information	_____ First Name Last Name _____ Daytime Phone Email	_____ Social Security Number _____ Date of Birth
Request For Spouse or Dependent Debit Card	I would like a Debit Cards for my ☐ Spouse or my ☐ Dependent. Please enter their name and Social Security number: _____ First Name Last Name _____ Spouse or Dependent Social Security Number	There is a one time $5.00 fee for additional Debit Cards that will be deducted from your HSA account.
Delivery Information	All additional debit cards will be mailed to the MyHSA Account Holder's address that we have on file.	There is a one time $5.00 fee for additional Debit Cards that will be deducted from your HSA account.
HSA Account Holder Authorization	I hereby certify that I authorize Alliance Benefit Group of Illinois as MyHSA administrator to issue the Debit Card(s) requested above and I agree to be bound by the terms and conditions relating to usage for the Debit Card(s). I agree to accept responsibility for any and all transaction initiated by my spouse and/or dependent listed above who have or may receive a Debit Card pursuant to this authorization. I acknowledge that fees related to the issuance of spouse and/or dependent Debit Cards will be withdrawn from my HSA account. _____ _____ Signature Date	

MAIL OR FAX A COPY OF THIS FORM TO:

Alliance Benefit Group
456 Fulton Street, Suite 345
Peoria, IL 61602
Or Fax the completed form to (800) 688-4329

If you have any questions please call customer service at 800-57 MyHSA (1-800-576-9472)