ALLEGIANCE
FLEX ADVANTAGE™

P.O. BOX 4346 • MISSOULA MT 59806
CUSTOMER SERVICE: 1-877-424-3570
FAX: 1-877-424-3539
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DEBIT CARD ENROLLMENT FORM

Personal Information

Employer _____

Name _____ SSN _____-_____-_____

Address _____ City _____State _____ Zip _____

Birth Date _____ ☐ Male ☐ Female ☐ Married ☐ Single

Email Address ▶

Spouse Information (complete only if your employer allows spouse cards)

Name _____ SSN _____-_____-_____

Birth Date _____

Dependent Information (complete only if your employer allows dependent cards)

Name _____ SSN _____-_____-_____

Birth Date _____

Cardholder Use Acknowledgement

1. I may only use the card to pay for eligible medical expenses.
2. I may not use the card for expenses already reimbursed.
3. I may not seek reimbursement under any other health plan for expenses paid with the card.
4. I will acquire and provide documentation for expenses paid with the card.
5. I have been provided an explanation of the fees associated with the debit card.

Employee Signature: _____ **Date:** _____

Spouse Signature: _____ **Date:** _____

As a security measure your card will be mailed in a plain white envelope. Please be careful not to throw it away with the junk mail!