Diversified Administration, Inc.
Tax Savings For Employers & Employees

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Benefits Card Enrollment Agreement

As a participant in one or more of your Employer Plans, you will receive a Benefits Card, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card and posted on the website.

You understand that the Benefits Card is restricted to certain merchant categories and is not accepted at all locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which you participate.

If the Card is issued pursuant to Employer Plans and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense. You agree to save all invoices and receipts related to any expense paid with the Card; upon request you must submit these documents for review by the Plan Service Provider.

Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

Your employer will be invoiced $5 per card requested. Some employers may ask the card holder to cover those fees, and other employers may cover the cost for you. Please be sure to consult with your HR department to see if you will be responsible for the fee.

Participant Information

For proper Cardholder Identification, please complete the following information.
Your Card will not be issued until this form is received by Diversified Administration, Inc.

☐ This is the first time I am ordering a Benefits Card
☐ This is to obtain original cards for my family members
☐ This is to replace a damaged card
☐ My card was LOST or STOLEN

Employer name: IAFF Local 587 Health Insurance Trust

Employee Name on Primary Card (21 chars max, including spaces): _____

Mailing Address: _____

Unit/Apartment Number: _____ City: _____ State: ZIP: _____

E-mail Address: _____

Last 4 of your Social Security Number: _____ Mother's Maiden Name: _____

Name on 2nd Card (21 chars max, including spaces) _____

Card Holder's Signature: _____