



Redwood Health Services

**Fax completed form to 707-525-4223 or mail to RHS at address below.**

# HRA Debit Card Agreement

Name of Employer \_\_\_\_\_ HRA Plan Year \_\_\_\_\_

Employee Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employee SS# \_\_\_\_\_  Male  Female Date of Hire \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_

**I understand and agree that:**

My employer and/or I have the right to suspend or terminate my card.

Any violation of my cardholder agreement will result in suspension or termination of my card.

Fraudulent use of my card under the limitations set forth by my employer and the IRS Code Section 105 regulations includes but is not limited to: purchase of non-eligible products or services; purchases for ineligible individuals; providing card access to inappropriate individuals; false claim submission to document transactions; failure to make the necessary fund replacement. These terms also apply to any extra cards that I may order.

I must retain all my RHS Debit Card receipts for my records in the event the IRS and/or RHS need to audit my account for Code Section 105 compliance.

**IMPORTANT:**

- Always show your insurance card FIRST.
- Your debit card should only be used for ELIGIBLE expenses.
- Replacements for lost debit cards cost \$5 per card.

By signing this document and the back of my RHS Debit Card, I certify that I have read, understand and agree to the terms above.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee's Printed Name: \_\_\_\_\_

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Redwood Health Services, 3033 Cleveland Ave. #104, Santa Rosa, CA 95403-2179

Questions? Call RHS Customer Service at 800-548-7677