



Redwood Health Services

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

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, 3510 Unocal Place, Suite 108, Santa Rosa, CA 95403

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