

## mySourceCard® Enrollment Agreement

As a participant in one or more of your Employer Plans or as an account holder under the HSA<sup>today</sup>™ program, you will receive a mySourceCard® MasterCard® Debit Card issued by Benefit Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance 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.

Please Note: Additional terms and conditions would apply if you use the Card to access your funds in your HSA under the HSA<sup>today</sup>™ program. In such event, these additional terms and conditions would be set forth in an HSA Addendum to your HSA custodial account agreement.

**For proper Cardholder Identification, please complete the following information.  
Your Card will not be issued until this form is received by your Plan Service Provider.**

Name on Card: (Please Print) \_\_\_\_\_  
21 characters maximum including spaces

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

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**\*\* If no email address is given, you authorize your employer to receive Protected Health Information on your behalf \*\***

Name on 2<sup>nd</sup> Card: (Please Print) \_\_\_\_\_  
21 characters maximum including spaces

Mother's Maiden Name (Security purposes only): \_\_\_\_\_

Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

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

*ALL FIELDS ARE REQUIRED*

### For Official Use Only

Plan Service Provider Initials:

Receive Date:

Process Date: