RULES OF PARTICIPATION AND AUTHORIZATION OF DEDUCTION
FLEX DEBIT CARD

I understand that:

- the card user must keep all receipts and provide them to American Fidelity Assurance Company, as requested.
- the Flex Debit Card may only be used at qualified medical providers.
- if the medical provider does not accept the Flex Debit Card, the card user will need to pay the expense and submit the claim for reimbursement to American Fidelity Assurance Company manually by mail or fax.
- if I do not respond to American Fidelity's request for receipts in a timely manner, access to the Flex Debit Card will be blocked and I will need to pay back the amount of the expense by either check or money order.
- if the Flex Debit Card is used to pay for an ineligible expense, I will be required to pay back the amount of the expense when requested by American Fidelity Assurance Company, by either check or money order.
- if I do not pay back the plan in a timely manner when requested to do so, my employer will be notified. My employer may make an after tax deduction or adjust my W-2 at the end of the tax year to make this correction.
- if the expense is greater than the amount available on the Flex Debit Card, the card swipe will be denied.
- there may be a fee charged to participate in the debit card program and, if so, I authorize my employer to payroll deduct this fee.
- that I will not receive a new debit card each year. Each subsequent year I participate, my new election amount will be loaded to my existing card. The debit card will expire 3 years from the date of issue.

If applicable, I certify that the additional Flex Debit Card will be provided to a person(s) who is:

- my eligible tax dependent or adult child as defined by the Internal Revenue Service, who is at least age 18 as of the first day of the plan year and who has not reached age 27 by the end of the tax year; or,
- my spouse.

When a dependent loses dependent status, I understand that I must notify American Fidelity immediately.

I am authorizing that an additional Flex Debit Card be issued in my dependent 's name which will be used in conjunction with my Health Flexible Spending Account (Unreimbursed Medical Account) offered by my employer. Dependents that have the additional Flex Debit Card will have access to my account information, including protected health information.

Participant Name:_____SSN:_____

Participant's Signature: _____ Date: _____

Employer Name: City of Pittsburg

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