INNOVA Benefit Services

mySourceCard® APPLICATION

Participant Information *(Please Print)*

Employer Name:	
Employee Name:	Social Security Number:
Street Address:	City, State, Zip:
Email Address:	Daytime Phone:

Request for Additional Card(s)

Please print name(s) as you would like them to appear on the card. (Maximum of 21 characters including spaces.)

Name :	Relationship to Employee:
Name:	Relationship to Employee:

Terms and Conditions

As a participant in one or more of the Reimbursement Plans sponsored by the Employer listed above, you are hereby electing to receive a *my*SourceCard® MasterCard® Debit Card issued by Armstrong Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card. You and your dependent(s) agree to use it according to the terms of this Agreement and the Cardholder Agreement that has been provided to you with the Card, including but not limited to:

1. You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard© acceptance locations.
2. You understand that you may not obtain a cash advance with the Card at any merchant, bank, or ATM.
3. You understand that the Card is to be used ***exclusively*** for Qualified Expenses as defined by the Plan(s) in which you participate.
4. If the Card is issued pursuant to a Reimbursement Plan as indicated on this form 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.
5. You agree to save all invoices and receipts related to any expense paid with the Card and upon request you must submit these documents for review by the Plan Service Provider.
6. 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, personal check or ACH draft, a deduction from your paycheck, or other options established by your employer.

The terms and conditions are not limited to the above. Please refer to the Cardholder Agreement.

Signature *(Signature & Date Required)*

Signature:	Date:

Submit This Form (*Via one of the following methods*)

Fax: 877.774.1328

Upload: www.innovaben.com/Files Submission/Claims

Mail: INNOVA Benefit Services, Processing Department, 795 Pine Valley Drive, Suite 21, Pittsburgh, PA 15239