P.O. BOX 4346 • MISSOULA MT 59806
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https://www.askallegiance.com/

# DEBIT CARD ENROLLMENT FORM

**Personal Information**

Employer ________________________________

Name ___________________________________ SSN __________-_______-__________

Address ___________________________ City ______________________State _____ Zip ___________

Birth Date ______________________ ☐ Male ☐ Female ☐ Married ☐ Single

Email Address ►

**Spouse Information** (complete only if your employer allows spouse cards)

Name ___________________________________ SSN __________-_______-__________

Birth Date _____________________

**Dependent Information** (complete only if your employer allows dependent cards)

Name ___________________________________ SSN __________-_______-__________

Birth Date _____________________

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Cardholder Use Acknowledgement

1. I may only use the card to pay for eligible medical expenses.
2. I may not use the card for expenses already reimbursed.
3. I may not seek reimbursement under any other health plan for expenses paid with the card.
4. I will acquire and provide documentation for expenses paid with the card.
5. I have been provided an explanation of the fees associated with the debit card.

**Employee Signature:** ________________________________________ **Date:** ______________

**Spouse Signature:** ___________________________________________ **Date:** ______________

**As a security measure your card will be mailed in a plain white envelope. Please be careful not to throw it away with the junk mail!**