ADDITIONAL FSA BENEFITS CARD REQUEST FORM

Employer Name:	County of San Mateo		
Employee Name:			
Employee SSN:			
Employee Street Address:			
	City:	State:	Zip:
Additional FSA Benefits Card: Information of Spouse or Dependent: (**dependent must be 18 years of age or older)			
Name:			
SSN:			
Date of Birth:			
Is shipping address different form employee address stated above?		☐ Yes	☐ No
If yes: Street Address:			
	City:	State:	Zip:
Relationship to Employee:	☐ Spouse	☐ Dependent (over 18 years of age)	

Submit this form to Benefit Coordinators by:

- Fax: 412-276-7367
- E-Mail: bcc-claims@benXcel.com
- Mail: Benefit Coordinators Corporation, Attn: Claims
  Two Robinson Plaza, Suite 200
  Pittsburgh, PA 15205
- Download to BCC's secure FTP website: http://secure.benxcel.com