

ADDITIONAL BENEFITS DEBIT CARD REQUEST FORM



Employer Name:		
Employee Name:		
Employee SSN:		
Employee Street Address:		
City:	State:	Zip:
Additional Benefits Debit Card Holder: Information of Spouse or Dependent <i>(dependent must be 18 years of age or older)</i>		
Name:		
SSN:		
Date of Birth:		
Is shipping address different from employee address stated above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: Street Address:		
City:	State:	Zip:
Relationship to Employee:	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent (over 18 years of age)	

Submit this form to Benefit Coordinators by:

- Fax: 412-276-7185
- 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>

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