

## SPOUSE CARD REQUEST FORM

Mail to:  
 UPMC Health Plan  
 PO Box 3169  
 Greenwood Village, Co 80155-3169

Phone: 1-888-876-2756  
 Fax: 1-866-229-3711

### PLAN INFORMATION

EMPLOYER NAME: \_\_\_\_\_

### EMPLOYEE INFORMATION

\_\_\_\_\_  
 First Name MI Last Name

\_\_\_\_\_  
 Member ID Number Daytime Phone Number Email Address

### SPOUSE INFORMATION

Please list legal spouse, as defined by IRC §152, to whom a Benefits Card should be issued.

\_\_\_\_\_  
 Spouse First Name MI Last Name

\_\_\_\_\_  
 Social Security Number Date of Birth

### EMPLOYEE AUTHORIZATION

By providing spousal information and signing the Spousal Card Request Form, I authorize and understand that one additional Benefit Card will be issued under the *MyFlex Advantage* plan. A card will only be issued to a legal spouse as defined by IRC §152. **Use of the card will directly affect my account balance.** I am fully responsible to ensure that my spouse complies with the rules and regulations regarding the use of the card as outlined in the cardholder agreement to which I agree to be bound.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by UPMC Health Plan: \_\_\_\_\_