AXISPLUS BENEFITS

AXISPlus Card Enrollment Agreement

EMPLOYER:	
EMPLOYEE HEALTH INSURANCE PLAN:	

As a participant in one or more of your Employer's Plans or as an account holder under the AxisPlus™ program, you will receive an AxisPlus® MasterCard® Debit Card issued by Benefit Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which you participate. If the Card is issued pursuant to Employer Plans 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.

You agree to save all invoices and receipts related to any expense paid with the Card; upon request you must submit these documents for review by the Plan Service Provider. 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, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

Please Note: Additional terms and conditions are outlined in the Cardholder Agreement enclosed with the Card.

FOR PROPER CARDHOLDER IDENTIFICATION, PLEASE COMPLETE THE FOLLOWING INFORMATION. YOUR CARD WILL NOT BE ISSUED UNTIL THIS FORM IS RECEIVED BY YOUR PLAN SERVICE PROVIDER. PLEASE PRINT CLEARLY.

NAME ON CARD (FIRST, MIDDLE, LAST. 21 CHARACTERS MAXIMUM INCLUDING SPACES):			
MOTHER'S MAIDEN NAME (SECURITY PURPOSES ONLY)			
ADDRESS:	CITY:	STATE:	ZIP CODE:
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	E-MAIL ADDRESS:	HOME PHONE:
NAME ON SECOND CARD (FIRST, MIDDLE, LAST. 21 CHARACTERS MAXIMUM INCLUDING SPACES):		RELATIONSHIP TO EMPLOYEE:	

BY SIGNING I AM SIGNIFYING THAT I HAVE READ AND AGREE TO THE CONDITIONS LISTED ABOVE.

SIGNATURE:	Date:

FOR INTERNAL USE ONLY		
ENTERED BY:	RECEIVE DATE:	PROCESS DATE: