

**EMPLOYEE INFORMATION**

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	WORK PHONE	HOME PHONE	

I have elected to participate in the Medical Care and/or Dependent Care Flexible Spending Account(s) under the Brevard Public Schools Flexible Benefit Plan. Pre-tax payroll deductions will be made from my pay and placed into the above account(s) for my use. I understand, accept, and agree to the following:

- I will receive the CORNERSTONE BENEFITS CARD - MASTER CARD ("Card") which I will use to pay for medical and/or dependent care expenses that are eligible under the Flexible Benefits Plan and not otherwise payable by any other source.
- The Card may only be used at medical and/or licensed dependent day care providers.
- I am fully responsible for my own and my dependent's use of the Card as stipulated in the disclosure statement that will come with the Card.
- I will be responsible to immediately refund to the Plan, either directly or through employer payroll deductions hereby authorized, any ineligible Card transactions made by either myself or my dependent listed below.
- I may be subject to Federal Income Taxes and penalties based on any ineligible Card transaction made by myself or my dependent.
- I agree to notify Cornerstone immediately if separated or divorced from my spouse.

With full understanding of the above, I request that you issue an additional CORNERSTONE BENEFITS CARD - MASTER CARD ("Card") for:

**DEPENDENT INFORMATION**

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
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**EMPLOYEE SIGNATURE**

SIGNATURE	DATE
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**Mail or Fax form to:**  
**Cornerstone Administrative Services, LLC - Attention: Customer Care**  
 1350 DIVISION ROAD, SUITE 301 WEST WARWICK, RI 02893 TOLL FREE PHONE: (800) 720-4460 TOLL FREE FAX: (866) 878-800