

REQUEST FOR REPLACEMENT OR DEPENDENT MBI CARD

EMPLOYER'S NAME _____

EMPLOYEE NAME _____

EMPLOYEE ADDRESS _____

CITY, STATE, ZIP _____

EMPLOYEE SS# _____

PHONE # _____

EMPLOYEE EMAIL ADDRESS _____

NAME OF DEPENDENT/SPOUSE _____

(NAME OF PERSON FOR WHOM YOU ARE REQUESTING A CARD. IF THIS IS A REPLACEMENT CARD FOR YOURSELF PLEASE WRITE THE WORD "REPLACEMENT".)

SOCIAL SECURITY # OF
DEPENDENT/SPOUSE _____

(NAME OF PERSON FOR WHOM YOU ARE REQUESTING A CARD)

DATE OF BIRTH OF
DEPENDENT/SPOUSE _____

NOTE: THERE IS A \$5.00 MBI FEE FOR EACH ADDITIONAL CARD.

PLEASE MAIL THIS FORM ALONG WITH PAYMENT TO:

**HFS BENEFITS
4 North Park Drive, Suite 500
HUNT VALLEY, MD 21030**