

FLEXIBLE BENEFITS ENROLLMENT FORM



Please print clearly

EMPLOYER:	DIVISION:		
SSN:	<input type="checkbox"/> OPEN ENROLLMENT: <input type="checkbox"/> NEW HIRE <input type="checkbox"/> CHANGE* EFFECTIVE DATE (mm/dd/yy):		
NAME:	BIRTH DATE (mm/dd/yyyy):		
MAILING ADDRESS:	PHONE:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE
CITY:	STATE:	ZIP:	EMAIL:

If you have not already signed up for direct deposit, it's easy. Visit the Allegiance flex website, www.askallegiance.com.

FLEXIBLE BENEFITS ELECTION AUTHORIZATION

DEDUCT INSURANCE PREMIUMS PRE-TAX	PER PAY PERIOD DEDUCTION	NUMBER OF PAY PERIODS	TOTAL ANNUAL AMOUNT ELECTED
<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL SPENDING _____	X _____	= _____
	DAYCARE _____	X _____	= _____

PAY PERIODS (check one) 52 = WEEKLY 26 = BI-WEEKLY (EVERY 2 WEEKS) 24 = SEMI-MONTHLY 12 = MONTHLY
 The "Total Annual Amount Elected" will be used to enter election amounts in the Allegiance system.

DEBIT CARD ELECTION AUTHORIZATION (IF OFFERED BY YOUR EMPLOYER)

Yes, I would like the flex debit card for the current plan year. Please provide an email address to receive debit card communications via email.

BY ELECTING THE FLEX DEBIT CARD:

- I have been provided an explanation of the fees associated with the debit card.
- I may not seek reimbursement under any other plan for expenses paid with the card.
- I may only use the card to pay for eligible expenses and will acquire and provide all requested documentation for those expenses.

CERTIFICATION I certify that these are my benefit elections and that:

- I authorize the "before-tax" deduction of a portion of my pay based on the elections above.
- My health FSA election is for medical, dental, and vision expenses for myself, my spouse, and my qualified dependents.
- My daycare FSA election is for the care of my tax dependent children, under age 13, or individuals unable to care for themselves, residing with me at least 8 hours each day.
- I understand that my unused contributions made to the FSA cannot be refunded to me and become the property of my employer.
- Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense.
- I understand that coverage applies only to expenses incurred within the plan year and during my period of employment.
- I understand that this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in status.

Both an employee signature and company authorization are required for enrollment to be completed.

Signature: _____ Date: _____

Company Authorization: _____ Date: _____

***If this is an election change, please indicate the qualifying event:**

_____ HR initials _____

OFEE 2017

For Allegiance use only

Group Number: _____ Date Completed: _____ Entered By (initials): _____