

Please print clearly

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

 If you have not already signed up for direct deposit, it's easy. Visit the Allegiance flex website [www.allegianceflexadvantage.com](http://www.allegianceflexadvantage.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 - 52 = WEEKLY    26 = BI-WEEKLY (every 2 weeks)    24 = SEMI-MONTHLY    12 = MONTHLY

The "per pay period deduction" 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.**
- Yes, I would like a card for my spouse. Check only if your employer allows spouse cards.

Name of spouse: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth date: \_\_\_\_\_

**BY ELECTING THE FLEX DEBIT CARD:**

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

**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.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Company Authorization: \_\_\_\_\_ Date: \_\_\_\_\_

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

HR initials \_\_\_\_\_

For Allegiance use only

Group Number: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Entered By (initials): \_\_\_\_\_