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LIMITED-PURPOSE FSA OPEN ENROLLMENT FORM

For Allegiance internal use only:

Group Number: _____ Plan Year: _____

Date Completed: _____ Entered By (initials): _____

Please print CLEARLY and complete ALL fields.

EMPLOYER:		PLAN YEAR _(mm/dd/yy) : _____ TO _____	
DIVISION:		SSN:	
NAME:		BIRTH DATE:	<input type="checkbox"/> M <input type="checkbox"/> Married <input type="checkbox"/> F <input type="checkbox"/> Single
MAILING ADDRESS:		PHONE:	
CITY:	ST:	ZIP:	EMAIL:

LIMITED-PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION

PER PAY PERIOD DEDUCTION	★ NUMBER OF PAY PERIODS	TOTAL ANNUAL AMOUNT ELECTED
\$ _____	X _____	= \$ _____
<small>(Group insurance premium election on reverse)</small>		

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION

PER PAYPERIOD DEDUCTION	★ NUMBER OF PAY PERIODS	TOTAL ANNUAL AMOUNT ELECTED
\$ _____	X _____	= \$ _____

★ PAY PERIODS

52 =WEEKLY 26 =BI-WEEKLY (every 2 weeks) 24 =SEMI-MONTHLY 12 = MONTHLY

Please check with your employer if you are unsure of the number of pay periods used for FSA deductions.

If there is a discrepancy between the "per pay period deduction" amount and the "total annual amount elected," the "per pay period deduction" will be used to enter election amounts in the Allegiance system.

I DECLINE TO PARTICIPATE IN THE LIMITED-PURPOSE HEALTH FSA AND DEPENDENT CARE FSA.

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

- I understand that only vision, dental, and some preventive expenses can be reimbursed under the limited-purpose health FSA.
- I authorize the "Before-Tax" deduction of a portion of my pay based on the elections above.
- My health FSA election is for dental and vision expenses for myself, my spouse and my qualifying dependents.
- My dependent care FSA election is for the care of my tax dependent children, under age 13, handicapped tax dependent, or elder tax dependent residing with me at least 8 hours each day.
- I am aware that my unused contributions made under this plan 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 is required for enrollment to be completed.

Signed: _____ Date: _____

Company Authorization: _____ Date: _____

OTHER IRS CODE SECTION 125 DEDUCTIONS REQUESTED

<u>INSURANCE PLAN</u>	<u>PREMIUM AMOUNT</u>	<u>PAY PERIODS</u>	<u>TOTAL ANNUAL AMOUNT</u>
GROUP HEALTH	_____	x _____	= _____
DENTAL	_____	x _____	= _____
VISION	_____	x _____	= _____
_____	_____	x _____	= _____
_____	_____	x _____	= _____
TOTAL			= _____

HEALTH FSA EXPENSE ESTIMATION WORKSHEET - OPTIONAL

<u>COMMON MEDICAL EXPENSES</u>	<u>AMOUNT</u>	<u>NOTES</u>
Dental:	_____	_____
Vision:	_____	_____

TOTAL ANNUAL EXPENSES: _____ divide Total Annual Expenses by the number of pay periods to get the per pay period deduction amount.

- List all eligible out-of-pocket dental and vision expenses for you, your spouse, and your qualifying dependents.
- The full annual amount elected is available for eligible dental and vision expenses incurred at any time during the plan year.

DEPENDENT CARE FSA

- A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you.
- The care must be necessary for you and your spouse (if married), to go to work or for your spouse's education.
- Care may be provided by anyone other than your spouse or your children under the age of 19.
- Expenses for schooling, kindergarten and above, overnight camp and nursing homes are not reimbursable.
- The maximum you can elect, in a calendar year, is equal to the smallest of the following:
 - \$5,000 – Married and filing federal taxes jointly or a single parent
 - \$2,500 – Married and filing a separate federal tax return
 - you or your spouse's earned income

An employee with a disabled spouse or a spouse who is a full-time student can elect up to \$250/month for one child and \$500/month for two or more children.

- The amount contributed, up to the amount of your annual election, is available for reimbursement.
- Do not include medical expense amounts in the day care account box.

- All elected "Before-Tax" amounts are exempt from Federal, State, FICA, and Medicare taxes.
- "Before-Tax" elections may reduce future Social Security benefits.
- Be conservative in the amount of your election. Any amount that is not used during the plan year will revert back to your employer. If you have a large expense coming up that you are not sure is reimbursable, call or email Allegiance:

1-877-424-3570

Flex-inquire@askallegiance.com