

P.O. BOX 4346 • MISSOULA MT 59806
 406-721-2222 • 877-424-3570

 P.O. BOX 2930 • TUALATIN OR 97062
 503-885-1888
www.allegianceflexadvantage.com

LIMITED FLEXIBLE BENEFITS MID-YEAR CHANGE/ELECTION FORM

For Allegiance internal use only:

Group Number: _____ Plan Year: _____

Date Completed: _____ Entered By (initials): _____

Please print CLEARLY and complete ALL fields.

EMPLOYER:	<input type="checkbox"/> CHANGE (Must be within 30 days of qualifying event) <input type="checkbox"/> NEW HIRE EFFECTIVE DATE (mm/dd/yy): _____		
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:

REASON FOR MID-YEAR CHANGE

The election change must mirror the qualifying event. Please contact an Allegiance representative for assistance in determining the allowable change of election. You may also consult the mid-year change matrix available on the Allegiance website.

 MARRIAGE DIVORCE BIRTH/ADOPTION DEATH CHANGE IN ELIGIBILITY FOR HEALTH BENEFITS

Additional qualifying events for the dependent care FSA only:
 CHANGE IN DAY CARE PROVIDER CHANGE IN COST OF DAY CARE CHANGE IN ELIGIBILITY TO ELECT DAY CARE

LIMITED- PURPOSE HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION

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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION

PER PAY PERIOD DEDUCTION	★ NUMBER OF PAY PERIODS	TOTAL ANNUAL AMOUNT ELECTED
\$ _____	<input checked="" type="checkbox"/> _____	= \$ _____

★ 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:

1. I understand that only vision, dental, and some preventive expenses can be reimbursed under the limited-purpose health FSA.
2. I authorize the "Before-Tax" deduction of a portion of my pay based on the elections above.
3. My health FSA election is for dental and vision expenses for myself, my spouse (if filing jointly), and my tax dependents.
4. 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.
5. I am aware that my unused contributions made under this plan cannot be refunded to me and become the property of my employer.
6. Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense.
7. I understand that coverage applies only to expenses incurred within the plan year and during my period of employment.
8. 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:	_____	

÷ Number of pay periods _____ = _____ Per pay period deduction amount

- List all eligible out-of-pocket dental and vision expenses for you, your spouse, and your 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