



**FLEXIBLE BENEFITS
MID-YEAR CHANGE/ELECTION FORM
FOR NEW QUALIFYING DEPENDENTS UP TO 27**

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For Allegiance internal use only:

Group Number: _____ Plan Year: _____

Date Completed: _____ Entered By (initials): _____

Please print CLEARLY and complete ALL fields.

EMPLOYER:		EFFECTIVE DATE (mm/dd/yy):	
DIVISION:		SSN:	
NAME:		BIRTH DATE(mm/dd/yyyy):	<input type="checkbox"/> M <input type="checkbox"/> Married <input type="checkbox"/> F <input type="checkbox"/> Single
MAILING ADDRESS:		PHONE:	
CITY:	ST:	ZIP:	EMAIL:
NAME OF 1 st NEW QUALIFYING DEPENDENT:		BIRTHDATE OF 1 st NEW QUALIFYING DEPENDENT (mm/dd/yyyy):	
NAME OF 2 nd NEW QUALIFYING DEPENDENT:		BIRTHDATE OF 2 nd NEW QUALIFYING DEPENDENT (mm/dd/yyyy):	
NAME OF 3 rd NEW QUALIFYING DEPENDENT:		BIRTHDATE OF 3 rd NEW QUALIFYING DEPENDENT (mm/dd/yyyy):	

FLEXIBLE BENEFITS ELECTION AUTHORIZATION

PLAN/ACCOUNT TYPE	EMPLOYEE ELECTION PER PAY PERIOD	+	EMPLOYER AMOUNT PER PAY PERIOD (If applicable)	=	TOTAL PER PAY PERIOD	x	NUMBER OF PAY PERIODS	=	TOTAL ANNUAL AMOUNT ELECTED
MEDICAL SPENDING	_____	+	_____	=	_____	x	_____	=	_____
HEALTH PREMIUM	_____	+	_____	=	_____	x	_____	=	_____
TOTAL	_____	+	_____	=	_____	x	_____	=	_____

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

1. I authorize the "before-tax" deduction of a portion of my pay based on the elections above and on the reverse side.
2. My health FSA election is for medical, dental, and vision expenses for myself, my spouse (if filing jointly), and my dependents.
3. I am aware that my unused contributions made to the health FSA cannot be refunded to me and become the property of my employer.
4. Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense.
5. I understand that coverage applies only to expenses incurred within the plan year, starting on the effective date above, and during my period of employment.
6. 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>
DENTAL	_____	x _____	= _____
VISION	_____	x _____	= _____
_____	_____	x _____	= _____
_____	_____	x _____	= _____
TOTAL =			_____

HEALTH FSA EXPENSE ESTIMATION WORKSHEET - OPTIONAL

<u>COMMON MEDICAL EXPENSES</u>	<u>AMOUNT</u>	<u>NOTES</u>
Deductibles & Co-pays:	_____	_____
Prescriptions:	_____	_____
Dental:	_____	_____
Vision:	_____	_____
Over-The-Counter/Alternative:	_____	_____
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 medical expenses for you, your spouse, and your dependents.
- Items which promote general good health, such as vitamins, supplements, weight loss programs, and massage, are ineligible without a doctor’s prescription for the item to treat a specific medical condition.
- The full annual amount elected is available for eligible medical expenses incurred at any time during the plan year.

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- 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