



FLEXIBLE BENEFITS & DEBIT CARD OPEN ENROLLMENT FORM

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503-885-1888

www.allegianceflexadvantage.com

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 – 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:

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION

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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION

PER PAY PERIOD 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.

DEBIT CARD ELECTION AUTHORIZATION

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 medical expenses.
- I may not use the card for expenses already reimbursed.
- I may not seek reimbursement under any other health plan for expenses paid with the card.
- I will acquire and provide documentation for expenses paid with the card.
- I have been provided an explanation of the fees associated with the debit card.

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

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 and on the reverse side.
- My health FSA election is for medical, 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, or individuals unable to care for themselves, residing with me at least 8 hours each day.
- I am aware that my unused contributions made to the health FSA and the dependent care 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 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>
Deductibles & Co-pays:	_____	_____
Prescriptions:	_____	_____
Dental:	_____	_____
Vision:	_____	_____
Over-The-Counter/Alternative:	_____	<u>MUST HAVE RX/DX FOR OTC DRUGS AND MEDICINES</u>

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 qualifying dependents.
- Also 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.

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