FLEXIBLE BENEFITS ENROLLMENT FORM

Allegiance® a Cigna Company

Please print clearly

EMPLOYER:	DIVISION:
SSN:	☐ OPEN ENROLLMENT: ☐ NEW HIRE ☐ CHANGE* EFFECTIVE DATE (mm/dd/yy):
NAME:	BIRTH DATE (mm/dd/yyyy):
MAILING ADDRESS:	PHONE: ☐ M ☐ F ☐ MARRIED ☐ SINGLE
CITY: STATE: ZIP:	EMAIL:

If you have not already signed up for direct deposit, it's easy. Visit the Allegiance flex website, www.allegianceflexadvantage.com.

FLEXIBLE BENEFITS ELECTION AUTHORIZATION

PLAN / ACCOUNT TYPE	EMPLOYEE DEDUCT. PER PAY PERIOD		EMPLOYER AMT. PER PAY PERIOD		TOTAL PER PAY PERIOD		NUMBER OF PAY PERIODS		TOTAL ANNUAL AMT. ELECTED
MEDICAL SPENDING	_____	+	_____	=	_____	x	_____	=	_____
DAYCARE	_____	+	_____	=	_____	x	_____	=	_____
HEALTH PREMIUM	_____	+	_____	=	_____	x	_____	=	_____
_____	_____	+	_____	=	_____	x	_____	=	_____

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. To set your second card up for use by a spouse or dependent, simply have that user sign the back of the card prior to use. Merchants should recognize the card as a stored-value benefits card.

BY ELECTING THE FLEX DEBIT CARD:

1. I may only use the card to pay for eligible expenses and will acquire and provide all requested documentation for those expenses.
2. I may not seek reimbursement under any other plan for expenses paid with the card.

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.
2. My health FSA election is for medical, dental, and vision expenses for myself, my spouse, and my qualified dependents.
3. 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.
4. I understand that my unused contributions made to the FSA cannot be refunded to me and become the property of my employer.
5. Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense.
6. I understand that coverage applies only to expenses incurred within the plan year and during my period of employment.
7. 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.

Signature: _____ Date: _____

Company Authorization: _____ Date: _____

***If this is an election change, please indicate the qualifying event/note election changes are for future dates of service:**

_____ HR initials _____

2017

For Allegiance use only

Group Number: _____ Date Completed: _____ Entered By (initials): _____

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