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.

LIMITED FLEXIBLE BENEFITS ELECTION AUTHORIZATION

DEDUCT INSURANCE PREMIUMS PRE-TAX		PER PAY PERIOD DEDUCTION		NUMBER OF PAY PERIODS		TOTAL ANNUAL AMOUNT ELECTED
☐ YES ☐ NO	DENTAL / VISION	_____	X	_____	=	_____
	DAYCARE	_____	X	_____	=	_____

PAY PERIODS (check one) ☐ 52 = WEEKLY ☐ 26 = BI-WEEKLY (EVERY 2 WEEKS) ☐ 24 = SEMI-MONTHLY ☐ 12 = MONTHLY

The "Total Annual Amount Elected" will be used to enter election amounts in the Allegiance system.

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, and my qualified dependents.
4. 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.
5. I understand that my unused contributions made to the FSA 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 are required for enrollment to be completed.

Signature: _____ Date: _____

Company Authorization: _____ Date: _____

***If this is an election change, please indicate the qualifying event:**

_____ HR initials _____

2016

For Allegiance use only

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

2806 Garfield, P.O. Box 4346, Missoula, MT 59806-4346
Phone: 877.424.3570 | Fax: 877.424.3539 | www.askallegiance.com