

# FLEXIBLE BENEFITS ENROLLMENT FORM

For Health Savings Plan members ONLY



Please print clearly

EMPLOYER: Cascade Designs, Inc.	DIVISION:		
SSN:	<input type="checkbox"/> OPEN ENROLLMENT: <input type="checkbox"/> NEW HIRE <input type="checkbox"/> CHANGE* EFFECTIVE DATE (mm/dd/yy):		
NAME:	BIRTH DATE (mm/dd/yyyy):		
MAILING ADDRESS:	PHONE:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> MARRIED <input type="checkbox"/> 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](http://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
<input type="checkbox"/> YES <input type="checkbox"/> 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 \_\_\_\_\_

For Allegiance use only

Group Number: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Entered By (initials): \_\_\_\_\_

2016