# LIMITED 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.askallegiance.com.**

## FLEXIBLE BENEFITS ELECTION AUTHORIZATION

| PLAN / ACCOUNT TYPE | EMPLOYEE ELEC. PER PAY PERIOD | | EMPLOYER AMT. PER PAY PERIOD | | TOTAL PER PAY PERIOD | | NUMBER OF PAY PERIODS | | TOTAL ANNUAL AMT. ELECTED |
|---|---|---|---|---|---|---|---|---|---|
| DENTAL / VISION | _____ | + | _____ | = | _____ | x | _____ | = | _____ |
| DAYCARE | _____ | + | _____ | = | _____ | x | _____ | = | _____ |
| HEALTH PREMIUM | _____ | + | _____ | = | _____ | x | _____ | = | _____ |
| _____ | _____ | + | _____ | = | _____ | x | _____ | = | _____ |
| _____ | _____ | + | _____ | = | _____ | x | _____ | = | _____ |
| _____ | _____ | + | _____ | = | _____ | x | _____ | = | _____ |

**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/note election changes are for future dates of service:**

_____ HR initials _____

2014

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**