

Please print clearly

| | | | |
|------------------|--------|---|---|
| EMPLOYER: | | 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"/> Married <input type="checkbox"/> F <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.

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 MEDICAL SPENDING _____ X _____ = _____ | | | |
| | DAYCARE _____ X _____ = _____ | | |

 ◆ PAY PERIODS - 52 = WEEKLY 26 = BI-WEEKLY (every 2 weeks) 24 = SEMI-MONTHLY 12 = MONTHLY
 The "per pay period deduction" will be used to enter election amounts in the Allegiance system.

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.**
- 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 expenses and will acquire and provide all requested documentation for those expenses.
- I may not seek reimbursement under any other plan for expenses paid with the card.
- I have been provided an explanation of the fees associated with the debit card.

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.
- My health FSA election is for medical, dental, and vision expenses for myself, my spouse, and my qualified dependents.
- 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.
- I understand that my unused contributions made to the 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 are required for enrollment to be completed.

Signed: _____ 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): _____