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FLEXIBLE BENEFITS & DEBIT CARD OPEN ENROLLMENT FORM

For Allegiance internal use only:

Group Number: _____ Plan Year: _____

Date Completed: _____ Entered By (initials): _____

Please print CLEARLY and complete ALL fields.

EMPLOYER:		PLAN YEAR:		TO	
DIVISION:		SSN:			
NAME:			BIRTH DATE:		<input type="checkbox"/> M <input type="checkbox"/> Married <input type="checkbox"/> F <input type="checkbox"/> Single
MAILING ADDRESS:			PHONE:		
CITY:		ST:	ZIP:	*EMAIL:	

FLEXIBLE BENEFITS ELECTION AUTHORIZATION

MEDICAL SPENDING ACCOUNT	DAY CARE ACCOUNT
\$ _____ PER PAY PERIOD ELECTION W – BW – SM – M (please check one)	\$ _____ PER PAY PERIOD ELECTION W – BW – SM – M (please check one)
\$ _____ ANNUAL AMOUNT ELECTED (Pay period amount x number of pay periods)	\$ _____ ANNUAL AMOUNT ELECTED (Pay period amount x number of pay periods)
PAY PERIODS: "W"=WEEKLY (52); "BW"=BI-WEEKLY(26); "SM"=SEMI-MONTHLY(24); "M"= MONTHLY (12)	

DEBIT CARD ELECTION AUTHORIZATION

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 medical expenses.
- I may not use the card for expenses already reimbursed.
- I may not seek reimbursement under any other health plan for expenses paid with the card.
- I will acquire and provide documentation for expenses paid with the card.
- I have been provided an explanation of the fees associated with the debit card.

GROUP HEALTH INSURANCE PAY PERIOD PREMIUM AMOUNT: \$ _____ W BW SM M (please check one)

I DECLINE TO HAVE ANY "BEFORE-TAX" DEDUCTIONS TAKEN FROM MY PAY CHECK.

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 medical spending account election is for medical, dental, and vision expenses for myself, my spouse (if filing jointly), and my tax dependents.
- My day care account 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 am aware that my unused contributions made under this plan cannot be refunded to me and become the property of my employer.
- Reimbursement account claims must be accompanied by documentation of the out-of-pocket expense.
- I understand that coverage applies only to expenses incurred during participation.
- I understand that this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in status.

Signed: _____ Date: _____

Company Authorization: _____ Date: _____

NOT REQUIRED: FOR EMPLOYEE USE IN ESTIMATING EXPENSES

MEDICAL SPENDING ACCOUNT WORKSHEET

<u>COMMON MEDICAL EXPENSES</u>	<u>ESTIMATED PLAN YEAR TOTAL</u>	<u>NOTES</u>
Estimated Vision Expenses:	_____	_____
Estimated Dental Expenses:	_____	_____
Estimated Prescriptions:	_____	_____
Estimated Over-The-Counter Items: (Vitamins & supplements only with RX/DX)	_____	_____
Estimated Other Medical Expenses: (Deductible, co-pays, alternative, etc.)	_____	_____
TOTAL ESTIMATED EXPENSES:	_____	Enter in the Medical Spending Box "Annual Amount Elected."

\div Number of pay periods = _____ **Enter in the Medical Spending Box "Per Pay Period Election."**

- All eligible out-of-pocket medical expenses for you, your spouse, and your dependents can be reimbursed regardless of insurance coverage.
- The medical spending account categories on this worksheet are intended only for your personal use in estimating your annual medical expenses.
- The full annual amount elected is available for eligible medical expenses incurred at any time during the plan year.

DAY CARE ACCOUNT

- A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you.
 - The care must be necessary for you and your spouse (if married), to go to work or for your spouse's education.
 - Care may be provided by anyone other than your spouse or your children under the age of 19.
 - Expenses for schooling, kindergarten and above, overnight camp and nursing homes are not reimbursable.
 - The maximum you can elect, in a calendar year, is equal to the smallest of the following:
 - \$5,000 – Married and filing federal taxes jointly or a single parent
 - \$2,500 – Married and filing a separate federal tax return
 - you or your spouse's earned incomeAn employee with a disabled spouse or a spouse who is a full-time student can elect up to \$250/month for one child and \$500/month for two or more children.
 - The amount contributed, up to the amount of your annual election, is available for reimbursement.
 - Do not include medical expense amounts in the day care account box.
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- All elected "Before-Tax" amounts are exempt from Federal, State, FICA, and Medicare taxes.
 - Services must be incurred during your period of employment within the plan year to be eligible for reimbursement.
 - Be conservative in the amount of your election. Any amount that is not used during the plan year will revert back to your employer. If you have a large expense coming up that you are not sure is reimbursable...**just ask Allegiance before you make your election: 1-877-424-3570, or inquire@askallegiance.com.**