Allegiance℠
by Cigna Healthcare

LIMITED FLEXIBLE BENEFITS ENROLLMENT FORM

Please print clearly

EMPLOYER:	DIVISION:	
SSN:	OPEN ENROLLMENT: NEW HIRE CHANGE* EFFECTIVE DATE (mm/dd/yy):	
NAME:	BIRTH DATE (mm/dd/yyyy):	DATE OF HIRE (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 _____

2024

For Allegiance use only

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