Allegiance℠ by Cigna Healthcare

Flexible Spending Account Enrollment Form

Instructions

1. Complete all sections of this form.
2. Securely email, mail, or fax completed form to:
   Secure Email: allegianceform@healthaccountservices.com
   Address: P.O. Box 2396 Fargo, ND 58108-2396
   Fax: (833) 480-7005
3. If you have any questions about completing this form, please contact Allegiance Advantage Consumer Services at (877)424-3570. We have representatives available Monday-Friday, 7:00 am to 7:00 pm CST.

Step 1: Consumer Information

*=*Required Fields*

*Employer Name (Do not abbreviate)

*Employee ID Number

*Consumer Name (First, MI, Last)

*Social Security Number

*Consumer Mailing Address

E-mail Address (If provided, all notifications will be sent via e-mail)

*City

*State

*Zip Code

Day Telephone

*Birth Date (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

*Pay Frequency (**Please circle one**):
Monthly / Semi-Monthly / Bi-Weekly (24) / Bi-Weekly (26) / Weekly / Other

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will be automatically enrolled in this portion of your Section 125 Plan; however, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. *Please Note: Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

*Enrollment Type **(Please circle one)**: Open Enrollment Period / New Hire

	Medical Spending Account *Limit set by employer*	**Dependent Care Account** *Limit set by employer up to IRS maximum*	**Limited FSA** *(If applicable)*
***Consumer Effective Date** *(mm/dd/yyyy)*			
***Annual Election**	$		
***Number of Pay Periods** (*Note: If enrolling mid-year, please enter the numberof remaining pay periods within the plan year after your effective date*)	÷		
***Per Pay Period Amount** *(To be deducted each pay period)*	=		

Step 4: Authorization or Refusal

Please select only **one.*

Allegiance℠ by Cigna Healthcare

Flexible Spending Account Enrollment Form

☐	**Consumer Authorization** I authorize my employer to reduce my pay on a per-pay-period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my re-
☐	**Consumer Refusal** I do not want to participate. I understand that by refusing to participate, I will be unable to enroll this plan year unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit the change within a reasonable amount of time as deemed by the IRS and my employer.

*Employer Signature *(Not required during open enrollment)*

*Date

*Consumer Signature

*Date