Print Form

ALLEGIANCE
FLEX ADVANTAGE™

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FLEXIBLE BENEFITS 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: **City of Helena**	PLAN YEAR ____ **TO** ____
DIVISION:	SSN:
NAME:	BIRTH DATE: / / ☐M ☐F ☐ Married ☐ Single
MAILING ADDRESS:	PHONE:
CITY: ST: ZIP: :	*EMAIL:

FLEXIBLE BENEFITS ELECTION AUTHORIZATION

MEDICAL SPENDING ACCOUNT	DAY CARE ACCOUNT
$____ **PER PAY PERIOD ELECTION** SM – 24 Pay Periods	$____ **PER PAY PERIOD ELECTION** SM – 24 Pay Periods
$____ **ANNUAL AMOUNT ELECTED** SM – 24 Pay Periods	$____ **ANNUAL AMOUNT ELECTED** SM – 24 Pay Periods

PAY PERIODS: "W"=WEEKLY (52); "BW"=BI-WEEKLY(26); "SM"=SEMI-MONTHLY(24); "M"= MONTHLY (12)

DEDUCT INSURANCE PREMIUMS PRE-TAX ☐YES ☐ NO

CERTIFICATION *I certify that these are my benefit elections and that:*

1. I authorize the "before-tax" deduction of a portion of my pay based on the elections above.
2. My medical spending account election is for medical, dental, and vision expenses for myself, my spouse (if filing jointly), and my tax dependents.
3. 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.
4. I am aware that my unused contributions made under this plan cannot be refunded to me and become the property of my employer.
5. Reimbursement account claims must be accompanied by documentation of the out-of-pocket expense.
6. I understand that coverage applies only to expenses incurred during participation.
7. 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

COMMON MEDICAL EXPENSES	ESTIMATED PLAN YEAR TOTAL	NOTES
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*."**

÷ 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
  - your or your spouse's earned income

  An 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.

- 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.**