ALLEGIANCE FLEX ADVANTAGE™

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FLEXIBLE BENEFITS & DEBIT CARD OPEN ENROLLMENT FORM

For Allegiance internal use only:

Group Number: 503711 Plan Year: 2011 - 2012

Date Completed: _____ Entered By (initials): _____

Please print CLEARLY and complete ALL fields.

EMPLOYER: **Lewis & Clark College**	Plan Year: **April 1, 2011** Through **March 31, 2012**		
NAME:			
SSN/EMPLOYEE ID:	BIRTH DATE: / /	SEX	MARITAL STATUS
MAILING ADDRESS:	PHONE:		
CITY:	ST	ZIP	*EMAIL:

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION
Plan Year Maximum - $6,000

Per Paycheck Deduction	Number Of Pay Periods	Total Annual Amount Elected
$	X 12	$

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA) ELECTION
Plan Year Maximum - $5,000

Per Paycheck Deduction	Number Of Pay Periods	Total Annual Amount Elected
$	X 12	$

DEBIT CARD ELECTION AUTHORIZATION

☐ Yes, I would like the flex debit card for the current plan year.
☐ Yes, I would like a card for my spouse (*Please note: IRS rules currently do not allow the use of flex accounts for Domestic Partners*).

NAME OF SPOUSE:	SSN:	BIRTH DATE: / /

BY ELECTING THE FLEX DEBIT CARD:

1. I have provided my email address to receive debit card communications via email*
2. I may only use the card to pay for eligible medical expenses.
3. I may not use the card for expenses already reimbursed.
4. I may not seek reimbursement under any other health plan for expenses paid with the card.
5. I will acquire and provide documentation for expenses paid with the card.

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 and on the reverse side.
2. My health FSA election is for medical, dental, and vision expenses for myself, my spouse (if filing jointly), and my tax dependents.
3. My dependent care 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.
4. I am aware that my unused contributions made to the health FSA and the dependent care FSA cannot be refunded to me and become the property of my employer.
5. Reimbursement requests, sent to Allegiance, must be accompanied by documentation of the expense.
6. I understand that coverage applies only to expenses incurred within the plan year and during my period of employment.
7. I understand that this agreement cannot be changed or revoked during the plan year unless I experience a qualified change in status.

Signature **Date**

Your application is not complete until the printed and signed version has been received by the Human Resources Office. Completed forms may be submitted as follows: Fax to 503-768-6233, email scanned forms to hr@lclark.edu, or hand deliver or US Mail to MSC 72 at 0615 S.W. Palatine Hill Road, Portland, Oregon 97219

HEALTH FSA EXPENSE ESTIMATION WORKSHEET – OPTIONAL

Common Medical Expenses	Amount	Notes
Deductibles & Co-pays:		
Prescriptions:		
Dental:		
Vision:		
Over-The-Counter/Alternative:		
Total Annual Expenses: _____ x 12 pay periods = _____ per paycheck deduction amount		

- List all eligible out-of-pocket medical expenses for you, your spouse, and your dependents.
- Items that promote general good health, such as vitamins, supplements, weight loss programs, and massage, are ineligible without a doctor's prescription for the item to treat a specific medical condition.
- The full annual amount elected is available for eligible medical expenses incurred at any time during the plan year.

DEPENDENT CARE FSA

- 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 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.
- "Before-Tax" elections may reduce future Social Security benefits.
- Be conservative in the amount of your election.
- Any amount that is not used during the plan year will revert to your employer.
- If you have a large expense coming up that you are not sure is reimbursable, call or email Allegiance at **1-877-424-3570 or** Flex-inquire@askallegiance.com