



Allied Benefit Systems, Inc.
200 West Adams, Suite 500
Chicago, IL 60606



P 800.288.2078
F 312.906.8879
E eligibility@alliedbenefit.com

Flexible Spending Account Enrollment Form

SECTION A EMPLOYER/EMPLOYEE INFORMATION			
Employer Name	Group Number	Employer Location (if applicable)	Effective Date
Employee Name	Employee SSN	Date of Birth	
Address	City	State	Zip
Employee Email Address	Daytime Phone	Employee Gender	
		Female	Male

SECTION B Election(s)					
Use the table below to select your Flex benefits. The option for Limited Purpose Flex (LPFSA) is only available to employees participating in a HDHP plan. Please note that if you elect participation in the LPFSA below, you may elect to participate in the DCA but not the FSA.					
	Annual/Mid Year Election Pledge	Divided By	# of Pay Periods: Annually / Mid Year	Equals	Deduction from each pay period
I elect to participate in the Health Flexible Spending Account		/		=	\$
I elect to participate in the Dependent Care Account		/		=	\$
(Plan Year Example)	\$2,650.00	/	24	=	Example \$110.42

SECTION C Allied Flex Debit Card SSN and DOB are required. Dependent must be over 17.					
Please complete the information below for all dependents who should have an Allied Flex Debit Card.					
Spouse Name:	Date of Birth:	SSN:	<input type="checkbox"/> Keep current dependent card active <input type="checkbox"/> Request new dependent debit card		
Dependent Name:	Date of Birth:	SSN:	<input type="checkbox"/> Keep current dependent card active <input type="checkbox"/> Request new dependent debit card		
Dependent Name:	Date of Birth:	SSN:	<input type="checkbox"/> Keep current dependent card active <input type="checkbox"/> Request new dependent debit card		
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SECTION D Direct Deposit	
I would like to participate in Direct Deposit: <div style="display: flex; justify-content: space-around;"> YES NO </div>	If yes, please complete the attached "Flex Direct Deposit Enrollment Form" and include a voided check.
I am currently participating in direct deposit. Please keep current banking information on file.	

SECTION E EMPLOYEE CERTIFICATION			
I certify the above information is true and correct and I authorize any premiums and HSA contributions, if applicable, to be paid on a pre-tax basis pursuant to Internal Revenue Code Section 125. I understand that any amounts which are not used for eligible expenses incurred during the Plan Year or Grace Period, will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the salary reduction(s) will be in effect for the Plan Year and cannot be revoked except as authorized by current Plan provisions and laws.			
Employee Signature		Date	
IF YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and I decline participation.			
Employee Signature		Date	
Employer Use Only (Required for processing)			
Employee's Flex Plan Effective Date	First Payroll Date	Payroll Cycle	I agree this form is correctly filled out by the Employee. HR Signature: