



**2006 Plan Year
Flexible Spending Accounts
Dependent Care and Healthcare Plans Update Form
Instructions**



Complete this form to make changes to or enroll in the HealthCare and/or Dependent Care Flexible Spending Account (FSA) when you have a midyear qualified status change (QSC). The Public Employees' Benefit Board (PEBB) must receive your completed form within 60 days following the QSC. PEBB must approve all midyear QSC-based changes prior to their implementation.

SECTION A – EMPLOYEE INFORMATION

Complete all portions of this section.

SECTION B – MIDYEAR QUALIFIED STATUS CHANGE

- Complete all portions of this section.
- In section B.1, check the change requested
- The annual maximum you may deposit into each account in 2006 is \$5,000.
- Use the information in Section 6 of in Volume II of the Benefit Booklet to estimate the amount of eligible, out-of-pocket expenses you anticipate you will have in 2006.
- Keep in mind: these are **spending** accounts, not **savings** accounts. If you don't incur the same level of out-of-pocket dependent care and/or healthcare expenses as you deposit in the account during the year and grace period, you will forfeit the balance. By IRS code, FSAs are "use it or lose it" accounts, so estimate conservatively.
- You can change this amount midyear only if you experience another qualified status change. Please refer to Section 6 in Volume II the Benefit Booklet.
- If you work less than 12 months in a calendar year, please carefully read Section 6 in Volume II of the Benefit Booklet to calculate your monthly contributions.
- When you terminate employment you may cancel participation in the program prior to processing of your final paycheck and may elect to stop the deduction from occurring on your final paycheck.
- You may also cancel participation when you begin an unpaid leave of absence.
- In both situations, if you return to state employment during the same plan year you may not participate in the program again until the next plan year unless you experience a separate and distinct QSC that is consistent with re-enrollment. Additionally, when you begin or return from an unpaid leave of absence your deductions automatically stop and start based on available earnings and the deduction priorities established by payroll practices and standards.
- In section B.2 enter the date the QSC occurred and select the QSC that applies to your specific request.

SECTION C – DEPENDENT INFORMATION

If you are enrolling for a DC FSA, list all individuals who qualify as eligible dependents in this plan. Your dependents **do not need to be enrolled** in any other PEBB plan to be eligible for this plan.

SECTION D – EMPLOYEE SIGNATURE AND AUTHORIZATION

Read this section carefully. Sign and date the form. Make a copy for your records, and submit your completed update form to:

Public Employees' Benefit Board
775 Court Street NE
Salem, OR 97301-3802

REIMBURSEMENT:

BenefitHelp Solutions (BHS) administers the FSA plans. When your account is established, BHS will send a form for you to use in requesting reimbursements for eligible expenses. Contact BHS at (503) 265-5710 or (877) 277-7279 if you have any questions about your FSA reimbursement or account balance.

**Flexible Spending Accounts (FSA) – Update Form
Dependent Care and Health Care Plans**



Please read the instructions on the reverse before completing this form.

A EMPLOYEE OR SUBSCRIBER INFORMATION				
<input type="checkbox"/> NEW EMPLOYEE – HIRE DATE				
LAST NAME		FIRST	MI	ID NUMBER (Benefit Number, SSN, University ID)
DATE OF BIRTH (MM-DD-YYYY)			GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
RESIDENCE ADDRESS <input type="checkbox"/> New Address		CITY	STATE	ZIP
		COUNTY	HOME PHONE	
MAILING ADDRESS (if different from above)		AGENCY		WORK PHONE

B MIDYEAR QUALIFIED STATUS CHANGE		
B.1 Change Requested		
<input type="checkbox"/> Enroll – Monthly contribution \$ _____		
<input type="checkbox"/> Change monthly contribution From \$ _____ to \$ _____		
<input type="checkbox"/> Cancel monthly contribution		
If you are terminating your employment, do you wish to cancel the deduction from your last pay check? <input type="checkbox"/> Yes <input type="checkbox"/> No		
B.2 QSC Date and QSC Event		
QSC Date (The date the event occurred)) (mm-dd-yyyy): _____		
<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce (final date)/Legal Separation <input type="checkbox"/> Birth <input type="checkbox"/> Adoption or placement for adoption <input type="checkbox"/> Death of a dependent <input type="checkbox"/> Dependent gains eligibility because:	<input type="checkbox"/> Dependent ceases to meet eligibility because: _____ <input type="checkbox"/> Gain other group coverage because: _____ <input type="checkbox"/> Involuntary loss of other group coverage.	<input type="checkbox"/> Employment status change (describe): _____ <input type="checkbox"/> Other; please explain: _____

C DEPENDENT INFORMATION				
List all eligible dependents. Your dependents do not need to be enrolled in any other PEBB plan to be eligible for this plan.				
Last Name	First	MI	Relationship	DOB (mm-dd-yyyy)

D EMPLOYEE SIGNATURE AND AUTHORIZATION	
I verify that I am eligible to participate in the PEBB Flexible Spending Account in which I am enrolling.	
I agree:	
<ul style="list-style-type: none"> Not to deduct or claim credit for any of the expenses reimbursed through the FSA plans on my individual income tax return. To file IRS Form 2441, or Schedule 2 if filing IRS Form 1040A. 	
I understand that:	
<ul style="list-style-type: none"> To be eligible to participate in the dependent care plan I must have and list my eligible dependents. The FSA plans are subject to current government regulations and to any future tax changes required by the government. The elections I have made are in effect, as long as eligibility requirements are met, for the 2006 plan year. If I do not incur the anticipated expenses during the plan year and grace period, or do not file for reimbursement by March 31, 2007, all dollars remaining in my account will be forfeited. These are "use-it-or-lose-it" accounts. I can change my contribution amount midyear only if I experience another qualified status change. This is an annual account, so I must enroll annually if I want to continue participation from year to year. I determine my deposits for the next year with each enrollment. 	
I have read the instructions on this form and the relevant benefit materials. I understand the limitations and qualifications of this program. I certify that the information I have provided on this form is accurate and correct, allowing for my participation.	
_____ Employee or Subscriber Signature	_____ Date

PEBB USE ONLY	
Approval Date: _____	PDB input: _____
Change effective date: _____	