

## Dependent Care Flexible Spending Account Enrollment Form

### Active Employee

### 2007 Plan Year – Instructions

Enroll online at <https://pebb.benefits.oregon.gov/members>

Complete this form to enroll for a Dependent Care Flexible Spending Account (FSA) for 2007, as a newly hired employee or during Open Enrollment.

Eligible employees may establish a Dependent Care flexible spending account to use pre-tax income to pay for eligible dependent care expenses.

Review detailed information on-line at [www.oregon.gov/DAS/PEBB](http://www.oregon.gov/DAS/PEBB) or refer to the PEBB Dependent Care FSA information in the 2007 PEBB Benefit Handbook.

- This is an annual account, so you must enroll each year if you want to participate. Because it is a “**use-it-or-lose-it**” account, you begin each year with a zero balance. You determine your deposits for the next year with each enrollment.
- Keep in mind: this is a **spending** account, not a **savings** account. If you do not incur the same level of out-of-pocket expenses that 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 will have until March 31, 2008, to submit claims for eligible expenses incurred during your participation in 2007. The IRS allows a “grace period” for FSAs; it runs from January 1 through March 15 in the year following the plan year. If you have funds remaining in your plan-year account and you incur eligible expenses during the grace period, those expenses may be reimbursed using previous plan-year deposits
- You will be reimbursed only for expenses incurred during your participation in the plan. If you enroll for an FSA after January 1, you can be reimbursed only for expenses you incur on or after the date your account goes into effect.
- Effective date of enrollment is the first of the month following the receipt of the appropriate forms or the qualifying status change (QSC) event, **whichever is later**.
- If you are enrolling during Open Enrollment, your first deduction will be taken from your first 2007 pay check.
- Active participation requires that you meet the criteria for eligible employee as defined by PEBB as an employee who works a minimum of 80 paid regular hours per month, is in a job share position, 0.5 FTE for an OUS employee or as defined by collective bargaining agreements. Participation will be terminated if you lose eligibility. You will need to re-enroll in the plan when you regain eligibility.
- **New for 2007 - Change in Reimbursement Process** - Dependent care reimbursement may only be made for services already provided. To expedite the release of the reimbursement, since you cannot be reimbursed until all dates of services have been rendered, you may want to submit your request on a weekly or bi-weekly basis.
- BenefitHelp Solutions (BHS) administers the FSA plans. When your account is established, BHS will send a welcome packet with a form for you to use in requesting reimbursements for eligible expenses. Contact BHS at (503) 765-3572 in Portland or (800) 556-2230 statewide if you have any questions about your FSA reimbursement or account balance.

#### SECTION A – EMPLOYEE INFORMATION

- Complete each item in this section.
- Check whether you are enrolling during Open Enrollment or as a new employee.
- If you are enrolling as a new employee, enter your hire date.

#### SECTION B – CONTRIBUTION AMOUNT

- Total Year Election:
  - If you participate in the Dependent Care FSA and you are married filing jointly, single or head of household, the limit is \$5,000.
  - If you are married and filing separately, the limit is \$2,500.
  - If both spouses work and participate in an FSA (even if through different employers), the \$5,000 limit applies to the combination of both FSAs
- You can change your contribution amount midyear because of and consistent with a QSC.
- If you work less than 12 months in a calendar year, calculate your monthly deposit based on the effective date of enrollment and the number of months you will work.
- If you are an OUS member enrolling in Dependent Care FSA and do not anticipate working 12 months you should contact your university benefit representative for additional information on allowable Dependent Care FSA contributions for the plan year.

#### SECTION C – DEPENDENT INFORMATION

List your dependents under the Dependent Care FSA. If you enroll in Dependent Care FSA, it is your responsibility to confirm that your dependents qualify under the PEBB program and that you are eligible to participate. Eligible dependents as defined by IRS regulations is an employee’s dependent child under the age of 13 or a disabled dependent of any age who is incapable of self-care and who spends at least eight hours per day in the employee’s home.

#### SECTION D – EMPLOYEE SIGNATURE AND AUTHORIZATION

Read this section carefully. Sign and date the form. Make a copy for your records, and submit the completed form to your agency/university payroll, personnel or benefits office.



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**SECTION A - EMPLOYEE INFORMATION**

<input type="checkbox"/> NEW EMPLOYEE		HIRE DATE :		<input type="checkbox"/> OPEN ENROLLMENT	
LAST	FIRST	MI	ID NUMBER (SSN, OUS#, Benefit #)		
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) <input type="checkbox"/> New Address		AGENCY		WORK PHONE	
EMAIL					

**SECTION B - CONTRIBUTION AMOUNT**

- Indicate the **monthly** amount you wish to contribute **through payroll deduction** to your Dependent Care FSA.
- OUS members please see instruction sheet for calculating your total year election.

Plan	Monthly Contribution	Number of Months	Total Year Election (Monthly Contribution x Number of Months)
Dependent Care FSA	\$		\$

**SECTION C - DEPENDENT INFORMATION**

List all eligible dependents. Your dependents **do not need to be enrolled** for coverage in any other PEBB plan.

Last Name:	First Name:	MI	Relationship:	DOB: (mm-dd-yyy)

**SECTION D - EMPLOYEE SIGNATURE AND AUTHORIZATION**

I verify that I am eligible to participate in the PEBB Dependent Care FSA.

I agree:

- Not to deduct or claim credit for any of the expenses reimbursed through an FSA on my individual income tax return.

I understand that:

- To be eligible to participate in the dependent care FSA, I must list my eligible dependents.
- FSAs are subject to current federal government regulations and to any future tax changes required by the federal government.
- The elections I have made are in effect, as long as eligibility requirements are met, for the 2007 plan year.
- If I do not incur the anticipated expenses during the plan year or grace period and I do not file for reimbursement by March 31, 2008, all dollars remaining in my account will be forfeited. This is a "use-it-or-lose-it" account.
- I can change my contribution amount during the year because of and consistent with a qualified status change.
- This is an annual account, so I must enroll during Open Enrollment 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 PEBB Benefit material. I understand the limitations and qualifications of this program.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

PEBB Use Only 09/06

Approved By: (initial)

Date:

Approved Effective Date:

PDB Updated By: (initial)