



Flexible Spending Account Enrollment

- Office Use Only -	
Approved by _____	Date _____
Effective Date _____	

See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml

Submit completed form to PEBB.

1. I am enrolling as a

<input type="checkbox"/> Newly Eligible Employee	<input type="checkbox"/> PEBB Member during Open Enrollment	<input type="checkbox"/> PEBB Member returning to work within 12 months
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2. I want to enroll in a

<input type="checkbox"/> Healthcare Flexible Spending Account (FSA)
<input type="checkbox"/> Dependent Care Flexible Spending Account (FSA)

3. Contact Information

PEBB Benefit Number (P#####), Employee ID, University ID

Last Name	First Name	MI	Agency #	Gender <input type="checkbox"/> F <input type="checkbox"/> M		
PEBB and the plans in which you enroll will send all benefit-related correspondence to your contact address.						
Contact Address	<input type="checkbox"/> Check if New Address	Apt #	City	State	Zip	County
Residence Zip Code	Work Zip Code	Personal E-mail (optional)	Work E-mail			
Date of Birth _ _ / _ _ / _ _ _ _	Home Phone (optional) () -	Work Phone () -				

4. Contribution - Healthcare FSA

Minimum monthly contribution is \$20.

Healthcare FSA	Monthly Contribution (minimum \$20)	Number of Months You Will Be Paid (9*, 10* or 12)	Total Year Election
Open Enrollment	\$ _____ X _____	=	\$ _____ (maximum=\$5,000)
Newly Eligible Employee	\$ _____		\$ _____ (maximum=\$5,000)

*Only certain OUS and ODE Academic employees may select 9 or 10 months (must fill out Section 6)

5. Contribution - Dependent Care FSA

Minimum monthly contribution is \$20 per FSA

Dependent Care FSA	Monthly Contribution (minimum \$20)	Number of Months You Will Be Paid (9*, 10* or 12)	Total Year Election
Open Enrollment (Total year maximum=\$5,000; \$2,500 if you are married and file taxes separately)	\$ _____ X _____	_____ =	\$ _____
Newly Eligible Employee (Total year maximum=\$5,000; \$2,500 if you are married and file taxes separately)	\$ _____ X _____	_____ =	\$ _____

*Only certain OUS and ODE Academic employees may select 9 or 10 months (must fill out Section 6)

6. Are you only paid 9 or 10 months of the year?

Please check the months you will not receive a paycheck. June July August September

7. Employee Signature and Authorization

I affirm I am eligible to participate in a Healthcare FSA Dependent Care FSA and that dependents for my dependent care claims meet related federal requirements.

(review www.oregon.gov/DAS/PEBB/docs/SPD/DCFSA.pdf)

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:

- An FSA is subject to federal government regulations.
- The elections I made are in effect as long as I continue to meet PEBB eligibility and participation requirements.
- If I do not incur my anticipated expenses for the FSA during the plan year, and I do not file for reimbursement by the end of the grace period, I will forfeit my remaining balance.
- I can request to change my contribution midyear only if I experience a qualified midyear plan-change event. The request must be consistent with the qualified event.
- This is an annual account. I must enroll during Open Enrollment to participate each plan year. I determine my contributions for the next year with each enrollment.

I understand the limitations and qualifications of this program.

Employee Signature

Date

Send to: Public Employees' Benefit Board
1225 Ferry Street SE, Salem, OR 97301

Or Fax: (503) 373-1654

Keep a copy of all benefit documents for your records