



2016

# Flexible Spending Account

- Office Use Only -

Approved by \_\_\_\_\_ Date \_\_\_\_\_

Effective Date \_\_\_\_\_

## 1. I am enrolling

**Newly Eligible Employee.** The coverage effective date is the first of the month following receipt of the completed forms or event date, whichever is later.

**New Hire Correcting enrollment elections** Complete Section 2, and only the sections that you want to correct.

## 2. Contact Information

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

**You must complete all fields. (Please Print)**

Last Name	First Name	MI	Agency #	Gender
				F M

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

Contact Address	Check if New Address	Apt #	City	State	Zip
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Residence Zip	Work Zip	Work Email	Personal E-mail (optional)
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Date of Birth (mm/dd/yyyy)	Work Phone	Home Phone (optional)
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**The Health Care and the Dependent Care FSAs are reimbursement accounts that you contribute a pre-tax amount to each month of the plan year from your paycheck.**

**Health Care FSA:** When you submit qualified health care expense claims for yourself and eligible dependents you receive reimbursement from the account.

**Dependent Care FSA:** When you submit a claim for qualified work-related expenses incurred for the care of a qualified dependent you receive a reimbursement from the account.

### Oregon State Payroll Employees (OSPS)

- OSPS employees must enroll for 12 monthly contributions.  
**Example:** Ann enrolls in the Health Care FSA for the plan year's maximum allowed contribution of \$2,550. Ann's monthly pretax contribution to the account will be \$212.50 each month.

### Oregon University (OUS) or Oregon Department of Education Employees (ODE)

- OUS and some ODE Academic employees select 9, 10, or 12 months, **based on number of paychecks received in the calendar year.** If you are unsure of your total paychecks contact your benefit office before you enroll.

**Example:** Ann wants to enroll in the Health Care FSA for the maximum yearly contribution of \$2,550. Ann is a ten month employee and does not receive a paycheck for July or August. Ann's FSA contribution is \$255.00 for 10 months.

**If you are an OUS or ODE employee with less than 12 paychecks, check the months you will NOT receive a paycheck**

June     July     August     September

**3. Healthcare FSA** Minimum monthly contribution is \$20. Maximum total year election is \$2,550

Healthcare FSA (Total year maximum = \$2,550)	Monthly Contribution (Minimum \$20)	Number of Months You Will Be Paid	Total Year Election
	\$ _____ X	_____ =	\$ _____

**4. Dependent Care FSA** Minimum monthly contribution is \$20. Maximum total year election is \$5,000

Dependent Care FSA (Total year maximum = \$5,000; \$2,500 if you are married and file taxes separately)	Monthly Contribution (Minimum \$20)	Number of Months You Will Be Paid	Total Year Election
	\$ _____ X	_____ =	\$ _____

**5. 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.

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 administered subject to federal treasury regulations.
- The elections I made are in effect as long as I continue to meet PEBB eligibility and participation requirements during 2016.
- **This is a Use-It-Or-Lose-It Account.** This account is non-refundable unless qualified claim reimbursements are submitted within the allowable time. If my qualified claim reimbursements during the plan year or grace period (see information on grace period at: <http://orpebb.asiflex.com/graceperiod.htm>) do not total my account balances or I do not file for a qualified claim reimbursement before the end of the grace period, I will forfeit my remaining account balance.
- I can request to change my monthly contribution midyear only if I experience a qualified midyear plan-change event that allows the change. The requested change must be consistent with the qualified event.
- This is an annual account, the account terminates at the end of each plan year (December 31). To have an account each plan year I must enroll during Open Enrollment. When I enroll I determine my total contribution for the year.

**I understand the limitations and qualifications of this program.**

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

\_\_\_\_\_  
Date

**Submit Form to:**

PEBB  
1225 Ferry St SE  
Salem, OR 97301

Salem: 503-373-1102  
Fax: 503-373-1654

**Keep a copy of your benefit forms for your records.  
Any alteration of this form may result in it being ineffective.**