

Flexible Spending Accounts (FSA) Open Enrollment Correction for 2016 Plan Year

Use this form only to request a correction to an enrollment error you made when you enrolled for a 2016 flexible spending account (FSA) during Open Enrollment.

Note: FSA enrollment after 12/31/2015 is not allowed unless there is a qualified midyear change or an employee is newly eligible.

Submit the completed form to PEBB.

Directions:

- Complete only the sections that you are requesting a correction for.
- Sign form
- Deliver, mail or fax the completed, signed form to PEBB

Deadlines for correcting open enrollment errors:

- **Employees paid through the Oregon State Payroll System (state agency employees).**
To correct an enrollment FSA error before 2016 benefits go into effect, you must submit this completed form no later than Dec. 31, 2015. To correct an open enrollment error after benefits go into effect, you must submit this completed form no later than Jan. 31, 2016.
- **Employees paid through the Oregon University System (state university employees)**
To correct an enrollment FSA error before 2015 benefits go into effect, you must submit this completed form no later than Dec. 31, 2015. To correct an enrollment error after benefits go into effect, you must submit this completed form no later than Feb. 28, 2016. (Corrections submitted by Dec. 12th will be adjusted in the December 2015 pay statement. Corrections submitted by January 13th will be adjusted in the January pay statement.)



Flexible Spending Open Enrollment Correction For 2016 Plan Year

- Office Use Only -

Approved by _____ Date _____

Effective Date _____

1. 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
Residence Zip	Work Zip	Work Email		Personal E-mail (optional)		
Date of Birth (mm/dd/yyyy)		Work Phone		Home Phone (optional)		
<p>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.</p> <p>Health Care FSA: When you submit qualified health care expense claims for yourself and eligible dependents you receive reimbursement from the account.</p> <p>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.</p> <p>Oregon State Payroll Employees (OSPS)</p> <ul style="list-style-type: none"> 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. <p>Oregon University (OUS) or Oregon Department of Education Employees (ODE)</p> <ul style="list-style-type: none"> 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 enrolling. 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. <p><u>If you are an OUS or ODE employee with less than 12 paychecks, check the months you will NOT receive a paycheck</u></p> <p style="text-align: center;"> <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> August <input type="checkbox"/> September </p>						

2. 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	_____ =	\$ _____

3. 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	_____ =	\$ _____

4. 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 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, which means it terminates at the end of each plan year. I must enroll during Open Enrollment to participate each plan year. I determine my contributions for the next year with each plan year enrollment

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.**