PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Healthcare FSA

Prepay Request

- Office Use Only -
Approved by __ Date___
Effective Date_____

Complete this form to request prepayment for a Healthcare Flexible Spending Account (FSA) before the beginning of your protected leave. See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml

Submit the completed form to PEBB.

1. Protected Leave Type

(check one):

- ☐ **Family and Medical Leave Act**
- ☐ **Active Duty Military Leave**
- ☐ **Continued Benefit of Injured Worker**

2. Contact Information

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

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	County

Residence Zip Code	Work Zip Code	Personal E-mail (optional)	Work E-mail

Date of Birth	Home Phone (optional)	Work Phone
_ _ / _ _ / _ _ _ _	( ) -	( ) -

3. Calculate Your Prepayment

Calculate the full contribution to be made during your leave in the current plan year.

Expected Leave — Number of Months on Leave

From: To:

Current Monthly Contribution | Number of Months on Leave | **Total Prepay Needed***

$ _____ X _____ = $ _____

Period for Prepayment (must be paid before leave begins) — Number of Months for Prepayment

From: To:

Monthly Contribution Increase | Number of Months for Prepayment | **Total Prepay Contribution***

$ _____ X _____ = $ _____

***Total Prepay Contribution amount must be equal to the Total Prepay Needed amount.**

4. Employee Signature and Authorization

I understand that my request will not be processed without verification of leave approval from my agency.

I also understand that:

- Eligible expenses incurred during the approved leave will be eligible for reimbursement only if I prepay the contribution before the leave starts.
- If my participation terminates during the leave, requests for reimbursement incurred after the termination will not be eligible for reimbursement.
- The effective date of this request is the first of the month following receipt of this form by the agency.

I certify that I have read the information and meet the requirements as indicated.

_____ _____

Employee Signature Date

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

Or Fax: (503) 373-1654

Office Use Only – Agency Approval

Name: _____

Date: _____

Keep a copy of all benefit documents for your records.

Print Form