pebb
Public Employees' Benefit Board

IRS Notice 2020-29
Health Care and Dependent Care FSA Midyear Change Form

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

Use this form to update your benefits no later than June 30, 2020. Forms received after this date will not be processed.

These plan elections or changes will go into effect the first of the month after this form is received.

Contact information

PEBB benefit number (P########), OR#, University ID or Lottery ID

Gender
◯ M ◯ F ◯ Other

Last name | First name | M.I.

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

☐ Check if new address

Address | Apartment or space#

City | State | ZIP | County

Date of birth (mm/dd/yyyy) | Work phone | Home phone (optional)

IRS Notice 2020-29 change event *(check all that apply)*

1. Select your action.
2. Healthcare expenses for domestic partners are ***not*** covered by an FSA unless your Domestic Partner qualifies as your current Federal Tax Dependent under IRS rules.
3. TDDP = 'Tax Dependent Domestic Partner'

Important note! You cannot cancel or decrease your Health Care FSA if you have been reimbursed more than your existing account balance.

HCFSA	Because of this event, I may:	◯ Enroll ◯ Increase ◯ Decrease ◯ Cancel
DCFSA	Because of this event, I may:	◯ Enroll ◯ Increase ◯ Decrease ◯ Cancel

Contribution Information

If yes, enter your monthly contribution amount, multiply by the number of months remaining in the calendar year in which you will receive a paycheck. This will be your total year election. NOTE: Effective date of changes are always prospective and are the first of the month following PEBB's receipt of this form. **Minimum monthly contribution is $20 per FSA.**

Oregon University or ODE employee with less than 12 paychecks in the plan year:

I will NOT receive a paycheck in the following months

☐ June ☐ July ☐ August ☐ September ☐ December

New Contributions

	Monthly contribution (minimum $20)	Number of remaining paychecks? (1-12)	Yearly contribution total
Healthcare FSA (Total year maximum = $2,700)	$_____ X	_____ =	$_____
Dependent Care FSA (Total year maximum = $5,000; $2,500 if you are married and file taxes separately)	$_____ X	_____ =	$_____

Did you change contribution amount?

Healthcare FSA monthly contribution	Current: $_____ (minimum $20)	To: $_____ (minimum $20)
Dependent Care FSA monthly contribution	Current: $_____ (minimum $20)	To: $_____ (minimum $20)

Employee signature and authorization

I affirm, that any dependents listed and I are eligible to participate in a Flexible Spending account, and that my FSA claims meet the related Federal requirements.

I understand that:

- An Flexible Spending Account is administered subject to Federal Tax regulations.
- Plans are subject to non-discrimination testing.
- The elections I made are in effect as long as I continue to meet PEBB eligibility and participation requirements for the plan year.
- **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 change event that allows the change. The requested change must be consistent with the qualified event.
- This is an annual account, which means it will end December 31st 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 will only be reimbursed for Health Care claims that are incurred during months that I have made contributions to my Health Care FSA.

☐ I understand the limitations and qualifications of this program.

Employee signature _____ Date _____

Keep a copy of your benefit forms for your records.

Any alteration of this form may result in it being ineffective.

Submitting your completed form:

Fax:	503-373-1654	**By Mail**
Email:	inquiries.pebb@dhsoha.state.or.us	PEBB Member Services 500 Summer Street NE, E-89 Salem, OR 97301-1063