pebb
Public Employees' Benefit Board

FSA Midyear Change
Healthcare Flexible Spending Account (HC FSA)
Dependent Care Flexible Spending Account (DC FSA)

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

See Summary Plan Description for more information at: www.pebbinfo.com.
Effective Date is first of the month following receipt of this form by PEBB or your agency/university payroll office.

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 your contact address.

☐ Check if new address

Address | Apartment or space#

City | State | ZIP | County

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

Resident zip code | Work zip code | Work email | Home email (optional)

Midyear event information

1. Find your midyear event, and select your action.
2. See the QSC matrix at www.pebbinfo.com for more information.
3. 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.
4. TDDP = 'Tax Dependent Domestic Partner'

Midyear event information *(continued)*

☐ I got married		Date:
HCFSA	Because of this event, I may:	◯ Enroll ◯ Increase
	Because I gained eligibility under my spouse/TDDP's HCFSA, I may: (you must complete spouse/TDDP info on page 4)	◯ Decrease
DCFSA	Because of this event, I may:	◯ Enroll ◯ Increase
	Because my spouse/TDDP works a different shift, is disabled or is a full-time student, I may:	◯ Decrease ◯ Cancel
	Because I gained eligibility under my spouse/TDDP's DCFSA, I may: (you must complete spouse/TDDP info on page 4)	◯ Decrease ◯ Cancel

☐ I lost my spouse/TDDP through divorce, annulment or death		Date:
HCFSA	Because I lost coverage under my spouse/TDDP's HCFSA plan, I may:	◯ Enroll ◯ Increase
	Because of this event, I may:	◯ Decrease
DCFSA	Because of this event, I may:	◯ Enroll ◯ Increase
	Because my dependent-care needs decreased, I may:	◯ Decrease
	Because I lost eligibility for a DCFSA, I may: (example: dependent now resides with ex-spouse/TDDP)	◯ Cancel

☐ I gained a dependent through birth, adoption, placement for adoption or affidavit. (i.e. Dependent gains eligibility) • You must also include the appropriate PEBB Affidavit Form		Date:
HCFSA	Because of this event, I may:	◯ Enroll ◯ Increase
	Because my spouse/TDDP enrolled in or increased contribution to an HCFSA, I may: (you must complete spouse/TDDP info on page 4)	◯ Decrease ◯ Cancel
DCFSA	Because of this event, I may:	◯ Enroll ◯ Increase
	Because my spouse/TDDP stopped working, I may:	◯ Cancel

☐ I lost a dependent or my dependent lost eligibility		Date:
HCFSA	Because of this event, I may:	◯ Decrease
DCFSA	Because of this event, I may:	◯ Decrease
	Because I no longer have eligible dependents, I may:	◯ Cancel

☐ I changed work hours or returned to work from a leave of absence		Date:
HCFSA	Because I returned from a leave of absence, I may:	◯ Enroll
DCFSA	I returned from a leave of absence, I may enroll only	◯ Enroll
	Because my dependent care needs increased, I may:	◯ Enroll ◯ Increase, consistent with the change in cost
	Because my dependent care needs decreased, I may:	◯ Decrease, consistent with the change in cost ◯ Cancel

☐ My spouse/TDDP has a change in employment or terminated employment		Date:
HCFSA	Because I lost coverage under my spouse/TDDP's HCFSA plan, I may:	◯ Enroll ◯ Increase
	Because I gained eligibility under my spouse/TDDP's HCFSA, I may:	◯ Decrease ◯ Cancel
DCFSA	Because I lost coverage under my spouse/TDDP's DCFSA plan, and my spouse/TDDP is seeking employment, a full-time student or disabled, I may:	◯ Enroll ◯ Increase
	Due to loss of eligibility for coverage, I may:	◯ Decrease ◯ Cancel

☐ Judgments, decrees or orders		Date:
HCFSA	This requires me to:	◯ Increase ◯ Decrease
DCFSA	No changes allowed.	

☐ Dependent care change in cost or coverage Please select the reason for the change along with the change to your DCFSA		Date:
DCFSA	◯ Because a change to a new daycare provider increased costs, I may: ◯ Because my spouse/TDDP's employer ceased to offer DCFSA, I may: ◯ Because my spouse/TDDP revoked a DCFSA during a different open enrollment period than PEBB's, I may:	◯ Enroll ◯ Increase, consistent with the change in cost
	◯ Because my daycare provider increased costs, I may: ◯ Because I increased the salary of my household employee (not my relative) who provides dependent care, I may:	◯ Increase, consistent with the change in cost
	◯ Because my spouse/TDDP enrolled in a new DCFSA, I may: ◯ Because my spouse/TDDP changed to a self-employed arrangement, decreasing dependent care costs, I may: ◯ Because a change to a new daycare provider decreased costs, I may: ◯ Because my dependent entered school for the first time, I may:	◯ Decrease, consistent with the chance in cost ◯ 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 months remaining in current year you will be paid	Total year election
Healthcare FSA (Total year maximum = $2,750)	$_____ X	_____ =	$_____
Dependent Care FSA (Total year maximum = $5,000; $2,500 if you are married and file taxes separately)	$_____ X	_____ =	$_____

Gained eligibility under spouse/TDDP

Plan type: ☐ Healthcare FSA ☐ Dependent Care FSA

_____

Spouse/TDDP's name

_____ _____

Employer Effective date

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 FSA 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 also understand that if I fail to report on this enrollment form a change that made an enrolled family member ineligible, PEBB may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.

☐ 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.

Be sure to save this form before emailing!

Submit your completed form:

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