

## 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](http://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	
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	
Last name	First name	M.I.	
PEBB and the plans in which you enroll will send <b>all</b> benefit-related correspondence to your contact address.			
<input type="checkbox"/> 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](http://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)*

<input type="checkbox"/> <b>I got married</b>		<b>Date:</b>
<b>HCFSA</b>	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
<b>DCFSA</b>	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
<input type="checkbox"/> <b>I lost my spouse/TDDP through divorce, annulment or death</b>		<b>Date:</b>
<b>HCFSA</b>	Because I lost coverage under my spouse/TDDP's HCFSA plan, I may:	Enroll Increase
	Because of this event, I may:	Decrease
<b>DCFSA</b>	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
<input type="checkbox"/> <b>I gained a dependent through birth, adoption, placement for adoption or affidavit. (i.e. Dependent gains eligibility)</b> • You must also include the appropriate PEBB Affidavit Form		<b>Date:</b>
<b>HCFSA</b>	Because of this event, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because my spouse/TDDP enrolled in or increased contribution to an HCFSA, I may: (you must complete spouse/TDDP info on page 4)	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel
<b>DCFSA</b>	Because of this event, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because my spouse/TDDP stopped working, I may:	<input type="checkbox"/> Cancel
<input type="checkbox"/> <b>I lost a dependent or my dependent lost eligibility</b>		<b>Date:</b>
<b>HCFSA</b>	Because of this event, I may:	<input type="checkbox"/> Decrease
<b>DCFSA</b>	Because of this event, I may:	<input type="checkbox"/> Decrease
	Because I no longer have eligible dependents, I may:	<input type="checkbox"/> Cancel

<input type="checkbox"/> <b>I changed work hours or returned to work from a leave of absence</b>		<b>Date:</b>
<b>HCFSA</b>	Because I returned from a leave of absence, I may:	<input type="checkbox"/> Enroll
<b>DCFSA</b>	I returned from a leave of absence, I may enroll only	<input type="checkbox"/> Enroll
	Because my dependent care needs increased, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase, consistent with the change in cost
	Because my dependent care needs decreased, I may:	<input type="checkbox"/> Decrease, consistent with the change in cost <input type="checkbox"/> Cancel

<input type="checkbox"/> <b>My spouse/TDDP has a change in employment or terminated employment</b>		<b>Date:</b>
<b>HCFSA</b>	Because I lost coverage under my spouse/TDDP's HCFSA plan, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because I gained eligibility under my spouse/TDDP's HCFSA, I may:	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel
<b>DCFSA</b>	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:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Due to loss of eligibility for coverage, I may:	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel

<input type="checkbox"/> <b>Judgments, decrees or orders</b>		<b>Date:</b>
<b>HCFSA</b>	This requires me to:	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease
<b>DCFSA</b>	No changes allowed.	

<b>Dependent care change in cost or coverage</b> Please select the reason for the change along with the change to your DCFSA		<b>Date:</b>
<b>DCFSA</b>	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:	<input type="checkbox"/> Enroll <input type="checkbox"/> 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:	<input type="checkbox"/> 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:	<input type="checkbox"/> Decrease, consistent with the change in cost <input type="checkbox"/> 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
<b>Healthcare FSA</b> (Total year maximum = \$2,750)	\$ _____ X _____	_____	= \$ _____
<b>Dependent Care FSA</b> (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?

<b>Healthcare FSA monthly contribution</b>	Current: \$ _____ (minimum \$20)    To: \$ _____ (minimum \$20)
<b>Dependent Care FSA monthly contribution</b>	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 PEBA 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.
- Enrollment effective dates are always prospective
- There are no refunds of contributions without an eligible expense.
- There is no transfer of money from one account to another.
- 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, PEBA may consider my omission an intentional misrepresentation of a fact material to my enrollment. In that case, PEBA may terminate the family member's coverage retroactively, pursuant to PEBA rules.

I understand the limitations and qualifications of this program.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date

## Submit your completed form:

**By Mail:**  
PEBA Member Services  
500 Summer Street NE, E-89  
Salem, OR 97301-1063

**Fax:** 503-373-1654

**Email:** [inquiries.pebb@dhsosha.state.or.us](mailto:inquiries.pebb@dhsosha.state.or.us)

**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!**