pebb
Public Employees' Benefit Board

2024 Open Enrollment & Correction
Healthcare Flexible Spending Account (HC FSA)
Dependent Care Flexible Spending Account (DC FSA)

Open Enrollment 10/01/2023 -10/31/2023
FSA Correction Period 11/01/2023-12/8/2023

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

All current FSA accounts terminate 12/31 each plan year. To have an FSA in 2024 you must sign up during Open Enrollment (10/01-10/31). **You cannot make an Open Enrollment Correction without completing Open Enrollment.**

Enrollment type

- ◯ Open Enrollment FSA (new enrollment for 2024 plan year)
- ◯ Open Enrollment correcting elections.
  I am making a correction to my FSA:
  - ☐ Amount ☐ Type ☐ Number of withdrawal months
- ☐ Cancel my Healthcare FSA ☐ Cancel my Dependent Care FSA

Enrolling in (check all that apply)

☐ Healthcare FSA ☐ Dependent Care FSA

Contact information (you must complete all fields)

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

Last name | First name | Middle | Gender ◯M ◯F ◯Other

☐ Check if new address

Contact address | Apartment # | City | State | ZIP

Residence ZIP code | Work ZIP code | Work email | Personal email (optional)

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

The Healthcare and Dependent Care FSAs are reimbursement accounts. You contribute a pre-tax amount from your monthly pay throughout the plan year to the account.

Healthcare FSA: When you submit qualified healthcare expense claims for yourself and eligible dependents you receive reimbursement from the account.

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.

Oregon State Payroll Employees (OSPS)

- OSPS employees must enroll for 12 monthly contributions.

  Example: Ann enrolls in the Healthcare FSA for the plan year's maximum allowed contribution of $3,050. Ann's monthly pretax contribution each month to the account is $254.16.

Oregon University or Oregon Department of Education Employees (ODE)

- Oregon University and some ODE Academic employees select 10 or 12 only based on number of paychecks received in the calendar year. If you are unsure of your total paychecks contact your payroll office before enrolling.

  Example: Ann wants to enroll in the Healthcare FSA for the maximum yearly contribution of $3,050. Ann is a ten month employee and does not receive a paycheck for July or August. Ann's FSA contribution is $305.00 for 10 months.

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

Healthcare FSA (Minimum monthly contribution is $20. Maximum total year election is $3,050.)

	Monthly contribution (Minimum $20)	Number of months you will be paid	Total year election
Healthcare FSA (Total year maximum = $3,050)	$ _____ X	_____ =	$ _____

Dependent Care FSA (Minimum monthly contribution is $20. Maximum total year election is $5,000.)

	Monthly contribution (Minimum $20)	Number of months you will be paid	Total year election
Dependent Care FSA (Total year maximum = $5,000; $2,500 if you are married and file taxes separately.)	$ _____ X	_____ =	$ _____

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 31, 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.

Submit your completed form to PEBB:	
Email: pebb.benefits@odhsoha.oregon.gov	**By Mail:** PEBB Member Services 500 Summer Street NE, E-89 Salem, OR 97301-1063
Fax: 503-373-1654	