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PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

# 2018 Flexible Spending Account

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

Submit this completed form to PEBB. For more information and to better understand FSAs go to http://orpebb.asiflex.com/

## I am enrolling as

- ☐ Newly Eligible Employee. The coverage effective date is the first of the month following receipt of the completed forms or event date, whichever is later.
- ☐ New Hire Correcting enrollment elections. Complete Section 2 and only the sections that you want to correct.
- ☐ Oregon FSA – only available to Oregon Registered Certificate of Domestic Partner.

## Contact information *(You must complete all fields)*

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

| Last name | First name | Middle | | Agency | Gender |
|---|---|---|---|---|---|
| | | | | | ☐ M ☐ F |
| Contact address | ☐ Check if new 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 Health Care and the Dependent Care FSAs are reimbursement accounts.**
**You contribute a pre-tax amount from your monthly pay throughout the plan year to the account.**

### Oregon State Payroll Employees (OSPS)

- OSPS employees must enroll for 12 monthly contributions.

  **Example 1:** Ann enrolls in the Health Care FSA during open enrollment. Ann's monthly pretax contribution each month to the account is $216.66.

  **Example 2:** Ann was hired in March and submitted her forms in March. Ann's effective date for the plan is April 1. Ann enrolls in the Health Care FSA for the plan year's maximum allowed contribution of $2,600. Ann's monthly contributions would be $288.88/month, effective April 1.

### Oregon University (OUS) or Oregon Department of Education Employees (ODE)

- OUS 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 benefit office before enrolling.

  **Example 1:** Ann enrolls in the Health Care FSA during open enrollment. Ann is a ten month employee and does not receive a paycheck for July or August. Ann's FSA contribution is $260.00 for 10 months.

  **Example 2:** Ann was hired in March and submitted her forms in March. Ann's effective date for the plan is April 1. Ann enrolls in the Health Care FSA for the plan year's maximum allowed contribution of $2,600. Ann receives 10 paychecks in a calendar year. Ann does not receive a paycheck for July or August. Ann's FSA contribution is $371.42 with a total of 7 contributions for the year (April, May, June, September, October, November and December).

**If you are an OUS or ODE employee with less than 12 paychecks in the plan year, check the months you will NOT receive a paycheck**

☐ June ☐ July ☐ August ☐ September

## Healthcare FSA *(Minimum monthly contribution is $20. Maximum total year election is $2,600.)*

| **Healthcare FSA** (Total year maximum = $2,600) | **Monthly contribution** (Minimum $20) | **Number of months you will be paid** | **Total year election** |
|---|---|---|---|
| | $ _____ X | _____ = | $ _____ |

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

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

## Employee signature and authorization

I affirm I am eligible to participate in a ☐ HealthcareFSA or a ☐ Dependent Care FSA, and that dependents for my dependent care claims meet the related federal requirements.

I agree not to deduct or claim credit for any of the expenses reimbursed through an FSA on my individual income tax return.

**I understand that:**

- An FSA is administered subject to federal Treasury regulations.
- 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

**Submit form to:** PEBB
500 Summer St NE, E89
Salem, OR 97301

Salem: 503-373-1102
Fax: 503-373-1654

**Keep a copy of your benefit forms for your records.**
**Any alteration of this form may result in it being ineffective.**