



# Flexible Spending Account (FSA)

## 2017 Open Enrollment

- Office Use Only -

Approved by \_\_\_\_\_ Date \_\_\_\_\_

Effective Date \_\_\_\_\_

**Submit this completed form to PEBB.**

- All 2016 FSA accounts terminate 12/31/2016, to have an FSA in 2017 you must enroll.
- After 12/31/2016 the Open Enrollment correction time period allows for corrections to existing FSA accounts, it does not allow a new account enrollment for 2017.

For more information and to better understand FSAs, go to <http://orpebb.asiflex.com/>

|   |                      |  |                       |                            |     |  |
|---|----------------------|--|-----------------------|----------------------------|-----|--|
| <b>1. Contact Information</b>   |                      | PEBB Benefit Number (P#####), Employee ID, University ID |                       |                            |     |  |
| <b>You must complete all fields. (Please Print)</b>   |                      |  |                       |                            |     |  |
| Last Name   | First Name           | MI   | Agency #              | Gender                     |     |  |
|   |                      |  |                       | F      M                   |     |  |
| PEBB and the plans in which you enroll will send <b>all</b> benefit-related correspondence to your contact address. |                      |  |                       |                            |     |  |
| Contact Address   | Check if New Address | Apt #  | City                  | State                      | Zip |  |
| Residence Zip   | Work Zip             | Work Email   |                       | Personal E-mail (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.**

**Health Care FSA:** When you submit qualified health care 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 Health Care FSA for the plan year's maximum allowed contribution of \$2,550. Ann's monthly pretax contribution each month to the account is \$212.50.

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

- OUS and some ODE Academic employees select 9, 10, or 12 months, **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:** Ann wants to enroll in the Health Care FSA for the maximum yearly contribution of \$2,550. Ann is a ten month employee and does not receive a paycheck for July or August. Ann's FSA contribution is \$255.00 for 10 months.

**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**

**2. Healthcare FSA** Minimum monthly contribution is \$20. Maximum total year election is \$2,550

| Healthcare FSA<br>(Total year maximum = \$2,550) | Monthly Contribution<br>(Minimum \$20) | Number of Months<br>You Will Be Paid | Total Year<br>Election |
|--|--|--------------------------------------|------------------------|
|  | \$ _____ X                             | _____ =                              | \$ _____               |

**3. Dependent Care FSA** Minimum monthly contribution is \$20. Maximum total year election is \$5,000

| Dependent Care FSA<br>(Total year maximum = \$5,000; \$2,500 if you are married and file taxes separately) | Monthly Contribution<br>(Minimum \$20) | Number of Months<br>You Will Be Paid | Total Year<br>Election |
|--|--|--------------------------------------|------------------------|
|  | \$ _____ X                             | _____ =                              | \$ _____               |

**4. Employee Signature and Authorization**

I affirm I am eligible to participate in a  Healthcare FSA 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 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

**Submit completed form by Oct. 31, 2016**

**Keep a copy of your benefit forms for your records.**

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