Flexible Spending Account
Enrollment

- Office Use Only -	
Approved by __	Date___
Effective Date_______	

See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml
Submit completed form to PEBB.

1. I am enrolling as

☐ **Newly Eligible Employee**	☐ **Active Employee during Open Enrollment for 2012 plan year.**
The coverage effective date is the first of the month following receipt of the completed forms or event date, whichever is later.	The coverage effective date is January 1, 2012. .

2. I want to enroll in

☐ Healthcare Flexible Spending Account (Healthcare FSA; complete section 4)
☐ Dependent Care Flexible Spending Account (Dependent Care FSA; complete section 5)

3. Contact Information

PEBB Benefit Number (P########), OR Number, University ID

Last Name	First Name	MI	Agency #	Gender ☐ F ☐ M

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

Contact Address	☐ Check if New Address	Apt #	City	State	Zip	County

Residence Zip Code	Work Zip Code	Work E-mail	Personal E-mail (optional)
Date of Birth _ _ / _ _ / _ _ _ _		Work Phone	Home Phone (optional)

4. Contribution – Healthcare FSA

Minimum monthly contribution is $20. Maximum total year election is $5,000.

Healthcare FSA	**Monthly Contribution** (minimum $20)	**Number of Months You Will Be Paid** (9*, 10* or 12)	**Total Year Election**
Open Enrollment (Total year maximum=$5,000)	$ ____________ X	____________ =	$ ____________
Newly Eligible Employee (Total year maximum=$5,000)	$ ____________	Effective date of enrollment is the first of the month following receipt of forms or event whichever is later. Calculate your monthly contribution based on the effective date and remaining months in the plan year.	

***Only certain OUS and ODE Academic employees may select 9 or 10 months (must fill out Section 6)**

5. Contribution – Dependent Care FSA

Minimum monthly contribution is $20. Maximum total year election is $5,000.

Dependent Care FSA	Monthly Contribution (minimum $20)	Number of Months You Will Be Paid (9*, 10* or 12)	Total Year Election
Open Enrollment (Total year maximum=$5,000; $2,500 if you are married and file taxes separately)	$ ______________ X	______________ =	$ ______________
Newly Eligible Employee (Total year maximum=$5,000; $2,500 if you are married and file taxes separately)	$ ______________	Effective date of enrollment is the first of the month following receipt of forms or event whichever is later. Calculate your monthly contribution based on the effective date and remaining months in the plan year.	

***Only certain OUS and ODE Academic employees may select 9 or 10 months (must fill out Section 6)**

6. Are you only paid 9 or 10 months of the year?

Please check the months you will not receive a paycheck. ☐ **June** ☐ **July** ☐ **August** ☐ **September**

7. Employee Signature and Authorization

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

(review www.oregon.gov/DAS/PEBB/docs/SPD/DCFSA.pdf)

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 subject to federal government regulations.
- The elections I made are in effect as long as I continue to meet PEBB eligibility and participation requirements.
- If I do not incur my anticipated expenses for the FSA during the plan year, and I do not file for reimbursement by the end of the grace period, I will forfeit my remaining balance.
- I can request to change my contribution midyear only if I experience a qualified midyear plan-change event. The request must be consistent with the qualified event.
- This is an annual account. I must enroll during Open Enrollment to participate each plan year. I determine my contributions for the next year with each enrollment.

I understand the limitations and qualifications of this program.

_______________________________ _______________________

Employee Signature Date

Send to: Public Employees' Benefit Board
1225 Ferry Street SE, Salem, OR 97301
Or Fax: (503) 373-1654

Keep a copy of all benefit documents for your records