

# FSA Open Enrollment Oct. 1 – Oct. 31, 2017

FSA 2018 Corrections (see dates below)

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

Submit this completed form to PEBB. **All 2017 FSA accounts terminate 12/31/2017, to have an FSA in 2018 you must enroll.** For more information and to better understand FSAs go to <http://orpebb.asiflex.com/>

## I am enrolling as

- Open Enrollment FSA
- Open Enrollment Oregon FSA – Only available to Oregon Registered Certificate of Domestic Partner.
- Open Enrollment Correction – An employee’s failure to take an enrollment action is not considered an employee enrollment error. An enrollment action means that the employee during the allowable enrollment times must take an action to enroll, add to, save or change benefit plan enrollment elections. A correction can be submitted by OSPS members through January 31, 2018 and OUS members through February 28, 2018

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

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

Last name	First name	Middle	Agency	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Contact address	<input type="checkbox"/> 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.**

**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 \$2,600. Ann’s monthly pretax contribution each month to the account is \$216.66.

### 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:** Ann wants to enroll in the Health Care FSA for the maximum yearly contribution of \$2,600. 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.

**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  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 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: 503-373-1102  
Salem, OR 97301 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.**