Submit this completed form to your agency/university benefit office. All 2018 FSA accounts terminate 12/31/2018, to have an FSA in 2019 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 time must take an action to enroll, add to, save a current enrollment or change benefit plan enrollment selections. A correction for open enrollment can be submitted through February 28, 2019. Corrections submitted after December 31, 2018 may be limited to follow IRS guidelines. Corrections may be prospective only.

Contact information (You must complete all fields)

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

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle</th>
<th>Agency</th>
<th>Gender</th>
<th>Contact address</th>
<th>Check if new address</th>
<th>Apartment</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

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 $2,650. Ann’s monthly pretax contribution each month to the account is $220.83.

### 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 $2,650. Ann is a ten month employee and does not receive a paycheck for July or August. Ann’s FSA contribution is $265.00 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**

<table>
<thead>
<tr>
<th>Month to Not Accept Paycheck</th>
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</thead>
<tbody>
<tr>
<td>☐ June</td>
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<tr>
<td>☐ July</td>
</tr>
<tr>
<td>☐ August</td>
</tr>
<tr>
<td>☐ September</td>
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</tbody>
</table>

### Healthcare FSA *(Minimum monthly contribution is $20. Maximum total year election is $2,650.)*

<table>
<thead>
<tr>
<th>Healthcare FSA</th>
<th>Monthly contribution (Minimum $20)</th>
<th>Number of months you will be paid</th>
<th>Total year election</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Total year maximum = $2,650)</td>
<td>$ ___________________________</td>
<td>__________________________</td>
<td>$ _________________</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Dependent Care FSA</th>
<th>Monthly contribution (Minimum $20)</th>
<th>Number of months you will be paid</th>
<th>Total year election</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Total year maximum = $5,000; $2,500 if you are married and file taxes separately.)</td>
<td>$ ___________________________</td>
<td>__________________________</td>
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</table>
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.
• Enrollment effective dates are always prospective
• There are no refunds of contributions without an eligible expense.
• There is no transfer of money from one account to another.
• 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.
Any alteration of this form may result in it being ineffective.
Submit this completed form to your agency/university benefit office.