## PEBB Dependent Care Flexible Spending Account Enrollment Form Active Employee

### 2008 Plan Year - Instructions

Enroll online at https://pebb.benefits.oregon.gov/members

Complete this form to enroll for a Dependent Care Flexible Spending Account (FSA) for 2008, as a newly hired employee or during Open Enrollment.

- Effective date for Open Enrollment is January 1, 2008. Effective date for a mid-year enrollment is the first of the month following receipt of the appropriate forms.
- If you terminate employment, no contribution to your account will be taken from your final pay.
- Application Software, Inc. (ASIFlex) administers the FSA plans. If you have any questions about your FSA reimbursement or account balance, contact ASI at 1-800-659-3035 or www.asiflex.com. Detailed information is available in the PEBB Benefit Handbook, on-line at <a href="https://www.oregon.gov/DAS/PEBB">www.oregon.gov/DAS/PEBB</a> or from ASI.

#### SECTION A - EMPLOYEE INFORMATION

• Complete each item in this section.

#### **SECTION B - CONTRIBUTION AMOUNT**

- Total Year Election: Calculate your monthly deposit based on the effective date of enrollment and the
  number of calendar months remaining in the year (Open Enrollment is 12 months). If you are an Oregon
  University member and do not anticipate working 12 months, contact your university benefit
  representative for additional information.
  - o If you are married filing jointly the limit is \$5,000 in the calendar year.
  - o Single or head of household the limit is \$5,000 in the calendar year.
  - o If you are married and filing separately the limit is \$2,500 in the calendar year.
  - o If both spouses work and participate in an FSA (even if through different employers), the \$5,000 limit in the calendar year applies to the combination of both accounts.

#### **SECTION C – DEPENDENT INFORMATION**

List your dependents under the Dependent Care FSA.

#### SECTION D - EMPLOYEE SIGNATURE AND AUTHORIZATION

- Read this section carefully, sign and date the form.
- Make a copy for your records and submit to your agency/university payroll, personnel or benefits office.



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SECTION A - EMPLOYE	E INFORMATION							
□ NEW EMPLOYEE HIRE DATE :						OPEN ENROLLMENT		
LAST	Ī	FIRST	MI		ID NUMBER (SSN, OUS		OUS#, Benefit #)	
DATE OF BIRTH (MM-DD-YYYY)			GEN	GENDER				
RESIDENCE ADDRESS		New Address	CITY	•		STATE	ZIP	
			COU	NTY		HOME PHO	ONE	
MAILING ADDRESS (if different from above)				GENCY		WORK PHONE		
E-MAIL								
SECTION B - CONTRIBU	TION AMOUNT							
Plan	Monthly Contribution	Number of Months			Total Year Election (Monthly Contribution x Number of Months)			
Dependent Care FSA	\$		\$					
CECTION O DEPENDE	NT INCORMATIO	N						
SECTION C - DEPENDE		dents <i>do not need to be</i>	enrolle	<b>d</b> for	coverage	in any oth	per PERR plan	
Last Name:			MI		elationship		DOB: (mm-dd-yyy)	
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SECTION D - EMPLOYE	E SIGNATURE A	ND AUTHORIZATION						
I verify that I am eligible to participate in the PEBB Dependent Care FSA. 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:  To be eligible to participate in the dependent care FSA, I must list my eligible dependents.								
<ul> <li>Fo be eligible to participate in the dependent care FSA, i must list my eligible dependents.</li> <li>FSAs are subject to current federal government regulations and to any future tax changes required by the federal government.</li> <li>The elections I have made are in effect, as long as PEBB eligibility requirements are met for the 2008 plan year.</li> <li>If I do not incur the anticipated expenses during the plan year or grace period and I do not file for reimbursement by March 31, 2009, I forfeit my remaining balance.</li> <li>I can change my contribution midyear only if I experience a qualified status change. The request must be consistent with the qualifying status change.</li> <li>This is an annual account I must enroll during Open Enrollment to continue participation from year to year. I determine my deposits</li> </ul>								
for the next year with each enrollment.								
I have read the PEBB Benefit material. I understand the limitations and qualifications of this program.								
Employee Signature					Date		<del></del>	
Employee Signature		"PEBB Use	Only"		Date			
Approved By: (initial)	Date:	Approved Effective	-		PDB Und	ated By: (in	itial)	