PEBB Dependent Care Flexible Spending Account (FSA)
Update Form Instructions
ww.oregon.gov/DAS/PEBB

Complete this form to make eligible election changes to your Dependent Care FSA outside of Open Enrollment. Please refer to your PEBB benefits handbook or web site for guidelines on qualified status changes (QSC).

- Submit one form per qualified status change.
- If you are **within 60 days of the QSC,** submit this form to your agency/university. If approved the effective date is the first of the month following either the date of the change or the agency/university receipt date, **whichever is later.**
- If you are **beyond 60 days of the date of the QSC,** submit this form to PEBB. If approved, PEBB will notify you of the coverage effective date.
- If you lose eligibility your participation ends. You must re-enroll in the plan when you regain eligibility.
- If you have questions about a claim or your account, contact Application Software, Inc.(ASIFlex) at 1-800-659-3035.

SECTION A - EMPLOYEE INFORMATION

- Complete all portions of this section.

SECTION B – QSC INFORMATION

B.1 Select the change requested.

B.2 Select the QSC and enter the date of the QSC. Processing of your request will not begin without the date.

- Total Year Election: (Calculate your monthly deposit based on the effective date of enrollment and the number of calendar months remaining in the year).
  - If you are married filing jointly – the limit is $5,000 in the calendar year.
  - Single or head of household – the limit is $5,000 in the calendar year.
  - If you are married and filing separately – the limit is $2,500 in the calendar year.
  - 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 eligible dependents.

SECTION D – EMPLOYEE SIGNATURE AND AUTHORIZATION

- Read, sign and date the form.
- Make a copy for your records and submit. **Sending your forms to the wrong address will delay your change.**

Active and Semi Independent Agency Employees,

Within 60 days of QSC to: Agency/University Payroll,
Personnel or Benefit Office

Outside 60 days of QSC to: PEBB
1225 Ferry St. SE
Salem, OR 97301-3802

PUBLIC EMPLOYEES PEBB BENEFIT BOARD

Dependent Care FSA
Update Form – Midyear Change Request

SECTION A - EMPLOYEE/SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	MI	ID NUMBER (SSN, University ID, Benefit #)

DATE OF BIRTH (MM-DD-YYYY)	GENDER ☐ FEMALE ☐ MALE

RESIDENCE ADDRESS ☐ New Address	CITY	STATE	ZIP
	COUNTY	HOME PHONE	
MAILING ADDRESS (if different from above) ☐ New Address	AGENCY	WORK PHONE	

EMAIL ADDRESS

SECTION B - QUALIFIED STATUS CHANGE (QSC) INFORMATION

B.1 Change you are requesting to your account:

☐ New enrollment – Monthly contribution $_____

☐ Re-enroll – Monthly contribution $_____

☐ Change monthly contribution from $_____ to $_____

☐ Cancel monthly contribution. **Note:** An employee ending employment will not have a deduction taken out of the final paycheck.

B2 Select the QSC and enter the Date that the QSC happened.

☐ Marriage
Date:_____

☐ Divorce (final date) or Legal Separation
Date:_____

☐ Birth
Date:_____

☐ Adoption or placement for adoption or affidavit of dependency
Date:_____

☐ Death of a dependent
Date:_____

☐ Dependent Gains eligibility
Date:_____

☐ Spouse enrolls in a new employer-sponsored dependent care FSA
Date:_____

☐ Employment Status – You or your spouse starts employment & establishes eligiblity for the program Date:_____

☐ Employment Status – You or your spouse starts employment (different shift), which eliminates or decreases need for dependent care
Date:_____

☐ Employment Status – You or your spouse changes work hours from part- time to full-time or vice versa, changing dependent care needs
Date:_____

☐ Employment Status – You or your spouse returns from leave of absence, resulting in dependent care needs Date:_____

☐ Employment Status – Your spouse Changes employment from a full-time job to self-employment, decreasing dependent care needs
Date:_____

☐ Employment Status – Your spouse terminates employment and loses FSA participation under a former employer, is seeking employment or is disabled or a full time student Date:_____

☐ Employment Status – Your spouse ends employment, is not seeking employment, is not disabled or is not a full-time student Date:_____

☐ Provider – Change to new dependent care provider (relative or not)
Date:_____

☐ Provider – Significant increase in the Cost of care (relative or not)
Date: _____

☐ Dependent child entering the school system for the first time Date: _____ ☐ Dependent ceases to meet eligibility Date:_____	☐ Employment Status – You or your spouse starts a leave of absence or a leave without pay Date:_____ ☐ Employment Status – Your spouse's employer stops offering a dependent care FSA Date: _____ ☐ Employment Status – Your spouse stops a dependent care FSA though an employer with an open enrollment period that differs from PEBB's Date: _____	☐ Provider – Increase in salary of a household employee (not your relative) who provides dependent care services Date: _____

SECTION C - DEPENDENT INFORMATION

List all dependents with eligible expenses for this account. Your dependents ***do not need to be enrolled*** in any other PEBB plan for expenses to be eligible for withdrawal from this account.

Last Name	First Name	MI	Relationship	DOB (mm-dd-yyyy)

SECTION D - EMPLOYEE SIGNATURE AND AUTHORIZATION

I certify that I am eligible to participate in the PEBB Dependent Care FSA.

I agree not to deduct or claim credit on my individual income tax return for any of the expenses reimbursed through the Dependent Cares FSA plan.

I understand that:

- It is my responsibility to confirm that my dependents qualify under the PEBB program and that I am eligible to participate.
- This Dependent Care FSA plan is subject to current federal government regulations and to any future tax changes required by the federal government.
- The elections I made are in effect, as long as I meet the eligibility requirements for the plan year.
- If I do not incur the anticipated expenses during the plan year and grace period and I do not file for reimbursement by March 31 of the following plan year, I forfeit the remaining money in my account.
- I can only change my contribution amount during the plan year because of and consistent with a qualified status change.
- This is an annual account. I must re-enroll during open enrollment to participate each New Plan Year. I must determine my contributions for the new plan year during each open enrollment.
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I have read the PEBB benefit material. I understand the limitations and qualifications of this program.

_____ _____

Employee Signature Date

PEBB Use Only

Approved by (initials): _____ Date:_____ Approved change effective date:_____ PDB updated by (initials): _____