PEBB Healthcare Flexible Spending Account (FSA)
Update Form Instructions

www.oregon.gov/DAS/PEBB

Complete this form to make eligible changes to your Healthcare 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 date 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 receipt date of the form by the agency/university, **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 QSC date. 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).
  - The annual maximum is $5,000.
  - If you participate in the Healthcare FSA and your spouse also has a Healthcare FSA through the state of Oregon or another employer, your individual contribution limit is still $5,000.
- When you terminate employment, you can stop participation in the program before your final paycheck processes **only** if you have a positive account balance at the time of termination. You may continue your Healthcare FSA under COBRA at the time your employment ends. COBRA contributions to your account are after taxes.

SECTION C - DEPENDENT INFORMATION

- You do not need to list your 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

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

PUBLIC EMPLOYEES PEBB BENEFIT BOARD

Healthcare FSA
Update Form – Midyear Change Request

SECTION A – EMPLOYEE INFORMATION

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

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-enrollment – 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.

NOTE: Domestic Partner and domestic partner's children who do not qualify as your IRS tax dependent are not eligible for Healthcare FSA reimbursments.

B. 2 Select the QSC and enter the Date that the QSC happened.

☐ Marriage
Date:_____

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

☐ Birth
Date:_____

☐ Death of spouse
Date:_____

☐ Gain child through adoption, placement for adoption or by an affidavit of dependency
Date:_____

☐ Death of a dependent child
Date:_____

☐ Dependent child gains eligibility Date:_____

☐ Dependent child ceases to meet eligibility
Date:_____

☐ Change in a legal Judgement, Decree or Order
Date:_____

☐ Gain or loss of Medicare or Medicaid
Date:_____

☐ You or your spouse start a leave of absence or a leave without pay
Date:_____

☐ Your spouse terminates employment and loses eligibility through employer for a Healthcare FSA
Date:_____

☐ You or your spouse returns from a leave of absence or a leave without pay and gains eligibility for a Healthcare FSA
Date:_____

☐ Your spouse starts employment and you gain eligibility under your spouse's Healthcare FSA
Date:_____

SECTION C - DEPENDENT INFORMATION

No dependent information is required.

SECTION D - EMPLOYEE SIGNATURE AND AUTHORIZATION

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

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

I understand that:

- It is my responsibility to confirm that I qualify under the PEBB program and that I am eligible to participate.
- This Healthcare FSA plan is subject to current federal government regulations and to any future tax changes required by the federal government.
- The elections I make 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 event.
- This is an annual account. I must re-enroll during each open enrollment to participate each New Plan Year. I must determine my contributions for the new plan year during each open enrollment.

I have read the PEBB benefit material. I understand the limitations and qualifications of this program.

_____ _____

Employee Signature Date

PEBB Use Only

Approved By PEBB (initials)_____ Date:_____ Effective Date: _____ PDB updated by:_____