PEBB Healthcare Flexible Spending Account Enrollment Form
Active Employee
2009 Plan Year – Instructions

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

Complete this form to enroll for a Healthcare Flexible Spending Account (FSA) for 2009, as a newly hired employee or during Open Enrollment.

- Effective date for Open Enrollment is January 1, 2009. Effective date for a mid-year enrollment is the first of the month following receipt of the appropriate forms or the event date, **whichever is later.**

- 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 ASIFlex at 1-800-659-3035 or www.asiflex.com. Detailed information is available on-line at www.asiflex.com or www.oregon.gov/DAS/PEBB in the Summary Plan Document.

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 **academic** or **university employee** your number of contributions for the year is based on the number of paychecks received in the year. For additional information contact your benefit representative.

    - The annual maximum is up to $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 up to $5,000.

SECTION C – DEPENDENT INFORMATION - You do not need to list your dependents under the Healthcare FSA.

SECTION D – EMPLOYEE SIGNATURE AND AUTHORIZATION

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

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Healthcare Flexible Spending Account Enrollment Form
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SECTION A - EMPLOYEE INFORMATION

☐ NEW EMPLOYEE HIRE DATE :			☐ OPEN ENROLLMENT
LAST	FIRST	MI	ID NUMBER (SSN, University, 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
E-MAIL			

SECTION B - CONTRIBUTION AMOUNT

See Instructions

Plan	Monthly Contribution	Number of Months	Maximum Allowable Election for the year is $5,000 (Monthly Contribution x Number of Months)
Healthcare FSA	$		$

SECTION C - DEPENDENT INFORMATION

No dependent information is required.

SECTION D - EMPLOYEE SIGNATURE AND AUTHORIZATION

I verify that I am eligible to participate in the PEBB Healthcare 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:

- FSAs are subject to current federal government regulations and to any future tax changes required by the federal government.
- The elections I have made are in effect, as long as PEBB eligibility requirements are met for the 2009 plan year.
- 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, 2010, I forfeit my remaining balance.
- I can change my contribution midyear only if I experience a qualified status change. The request must be consistent with the qualifying status change.
- This is an annual account I must enroll during Open Enrollment to continue participation from year to year. I determine my deposits for the next year with each enrollment.

I understand the limitations and qualifications of this program.

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Employee Signature Date:

PEBB Use Only

Approved By: (initial) **Date:** **Approved Effective Date:** **PDB Updated by: (initial)**