



2012 Flexible Spending Account

Open Enrollment Correction

- Office Use Only -
Approved by ___ Date ___
Effective Date _____

Use this form only to request a correction to an enrollment error you made when you enrolled for 2012 flexible spending account(s) (FSA) during Open Enrollment. Not enrolling for a 2012 benefit during Open Enrollment is not a correctable enrollment error. **Submit completed form to PEBB.**

1. Contact Information

PEBB Benefit Number (P#####), Employee ID, University ID
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Last Name	First Name	MI	Agency #	Gender <input type="checkbox"/> F <input type="checkbox"/> M		
PEBB and the plans in which you enroll will send all benefit-related correspondence to your contact address.						
Contact Address	<input type="checkbox"/> Check if New Address	Apt #	City	State	Zip	County
Residence Zip Code	Work Zip Code	Work E-mail		Personal E-mail	(optional)	
Date of Birth _ _ / _ _ / _ _ _ _		Work Phone		Home Phone	(optional)	

2. Corrective Action

Select from the following actions to correct an error you made in enrolling for 2012 Flexible Spending Account during Open Enrollment.

Health Care Flexible Spending Account (Health Care FSA) Check all that apply. <input type="checkbox"/> Change my contribution amount (Complete Section 3) <input type="checkbox"/> Cancel my enrollment in a Health Care FSA <input type="checkbox"/> Change my enrollment from a Health Care FSA to a Dependent Care FSA (Complete Section 4)	Dependent Care Flexible Spending Account (Dependent Care FSA) Check all that apply <input type="checkbox"/> Change my contribution amount (Complete Section 4) <input type="checkbox"/> Cancel my enrollment in a Dependent Care FSA <input type="checkbox"/> Change my enrollment from a Dependent Care FSA to a Health Care FSA (Complete Section 3)
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3. Contribution - Health Care FSA

Minimum monthly contribution is \$20. Maximum total year election is \$5,000.

Healthcare FSA	Monthly Contribution (minimum \$20)	Number of Months You Will Be Paid (9*, 10* or 12)	Total Year Election
Open Enrollment	\$ _____ X _____	=	\$ _____ (maximum=\$5,000)

***Only certain OUS and ODE Academic employees may select 9 or 10 months (must fill out Section 5). Verify your eligibility for this option with your payroll or benefits office.**

4. Contribution - Dependent Care FSA

Minimum monthly contribution is \$20. Maximum total year election is \$5,000.

Dependent Care FSA	Monthly Contribution (minimum \$20)	Number of Months You Will Be Paid (9*, 10* or 12)	Total Year Election
Open Enrollment (Total year maximum=\$5,000; \$2,500 if you are married and file taxes separately)	\$ _____	X _____	= \$ _____

***Only certain OUS and ODE Academic employees may select 9 or 10 months (must fill out Section 5). Verify your eligibility for this option with your payroll or benefits office.**

5. Are you only paid 9 or 10 months of the year?

Please check the months you will not receive a paycheck. June July August September

6. Employee Signature and Authorization

I affirm I am eligible to participate in a Healthcare FSA Dependent Care FSA and that dependents for my dependent care claims meet related federal requirements.

(review www.oregon.gov/DAS/PEBB/docs/SPD/DCFSA.pdf)

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 subject to federal government regulations.
- The elections I made are in effect as long as I continue to meet PEBB eligibility and participation requirements.
- If I do not incur my anticipated expenses for the FSA during the plan year, and I do not file for reimbursement by the end of the grace period, I will forfeit my remaining balance.
- I can request to change my contribution midyear only if I experience a qualified midyear plan-change event. The request must be consistent with the qualified event.
- This is an annual account. I must enroll during Open Enrollment to participate each plan year. I determine my contributions for the next year with each enrollment.

I understand the limitations and qualifications of this program.

Employee Signature

Date

Send to: Public Employees' Benefit Board
1225 Ferry Street SE, Salem, OR 97301

Or Fax: (503) 373-1654

Keep a copy of all benefit documents for your records