

	Flexible Spending Account	- Office Use Only -
	Midyear Change	Approved by ___ Date ___
		Effective Date _____

See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml

Submit completed form to PEBB.

1. Contact Information

PEBB Benefit Number (P#####), Employee ID, University ID						
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	Personal E-mail	(optional)		Work E-mail	
Date of Birth	Home Phone	(optional)		Work Phone		
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2. Tips for using this form

1. Select the event you experienced

2. Enter the date it happened

<div style="border: 1px solid red; padding: 2px; margin-bottom: 5px;">3. Locate the flexible Spending account affected by your event</div> <ul style="list-style-type: none"> HCFSA – Healthcare flexible spending account DCFSA – Dependent care flexible spending account 	<input checked="" type="checkbox"/> I got married	Date: _____
<div style="border: 1px solid red; padding: 2px; margin-bottom: 5px;">4. Locate the reason that supports your action.</div>	This event allows me to make these changes Because I gained eligibility under my spouse's HCFSA, I may (must fill out section 5)	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input checked="" type="checkbox"/> Cancel

5. Locate and select an action.

3. Midyear Event Information

See the matrix at <http://www.oregon.gov/DAS/PEBB/docs/SPD/QSCmatrix.pdf> for more information.
Find your midyear event, and select your action.

Note: Healthcare expenses for domestic partners are not covered by an FSA unless your domestic partner qualifies as your dependent under IRS rules.

<input type="checkbox"/> I got married		Date:
HCFSA	Because of this event, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because I gained eligibility under my spouse's HCFSA, I may: (must fill out Section 6)	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel
DCFSA	Because of this event, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because my spouse works a different shift, is disabled or is a full-time student, I may:	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel
	Because I gained eligibility under my spouse's DCFSA, I may: (must fill out Section 6)	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel
<input type="checkbox"/> I lost my spouse through divorce, annulment or death		Date:
HCFSA	Because I lost coverage under my spouse's HCFSA plan, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because of this event, I may:	<input type="checkbox"/> Decrease
DCFSA	Because of this event, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because my dependent-care needs decreased, I may:	<input type="checkbox"/> Decrease
	Because I lost eligibility for a DCFSA, I may: (example: dependent now resides with ex-spouse)	<input type="checkbox"/> Cancel
<input type="checkbox"/> I gained a dependent through birth, adoption, placement for adoption or affidavit		Date:
HCFSA	Because of this event, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because my spouse enrolled in or increased contribution to an HCFSA, I may: (must fill out Section 6)	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel
DCFSA	Because of this event, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because my spouse stopped working, I may:	<input type="checkbox"/> Cancel
<input type="checkbox"/> My dependent gained eligibility		Date:
HCFSA	Because of this event, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
DCFSA	Because of this event, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
<input type="checkbox"/> I lost a dependent or my dependent lost eligibility		Date:
HCFSA	Because of this event, I may:	<input type="checkbox"/> Decrease
DCFSA	Because of this event, I may:	<input type="checkbox"/> Decrease
	Because I no longer have eligible dependents, I may:	<input type="checkbox"/> Cancel

<input type="checkbox"/> I <input type="checkbox"/> my spouse changed work hours or returned to work from a leave of absence		Date:
HCFSA	Because I returned from a leave of absence, I may:	<input type="checkbox"/> Enroll
	Because I gained eligibility under my spouse's HCFSA, I may: (must fill out Section 6)	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel
DCFSA	Because I or my spouse returned from a leave of absence, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because my dependent care needs increased, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because my dependent care needs decreased, I may:	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel
<input type="checkbox"/> My spouse terminated employment or began a leave of absence		Date:
HCFSA	Because I lost coverage under my spouse's HCFSA plan, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
DCFSA	Because I lost coverage under my spouse's DCFSA plan, and my spouse is seeking employment, a full-time student or disabled, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	Because my dependent care needs decreased, I may:	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel
<input type="checkbox"/> Judgments, Decrees or Orders		Date:
HCFSA	This requires me to: _____	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease
DCFSA	No changes allowed.	
<input type="checkbox"/> Dependent Care Change in Cost or Coverage		Date:
Please select the reason for the change along with the change to your DCFSA		
HCFSA	No changes allowed	
DCFSA	<input type="checkbox"/> Because a change to a new daycare provider increased costs, I may: <input type="checkbox"/> Because my spouse's employer ceased to offer DCFSA, I may: <input type="checkbox"/> Because my spouse revoked a DCFSA during a different open enrollment period than PEBB's, I may:	<input type="checkbox"/> Enroll <input type="checkbox"/> Increase
	<input type="checkbox"/> Because my daycare provider increased costs, I may: <input type="checkbox"/> Because I increased the salary of my household employee (not my relative) who provides dependent care, I may:	<input type="checkbox"/> Increase
	<input type="checkbox"/> Because my spouse enrolled in a new DCFSA, I may: <input type="checkbox"/> Because my spouse changed to a self-employed arrangement, decreasing dependent care costs, I may: <input type="checkbox"/> Because a change to a new daycare provider decreased costs, I may: <input type="checkbox"/> Because my dependent entered school for the first time, I may:	<input type="checkbox"/> Decrease <input type="checkbox"/> Cancel

4. Did you enroll in an FSA?

If yes, enter your monthly contribution amount, multiply by the number of months you will be paid in a full calendar year and enter the total year election. **Minimum monthly contribution is \$20 per FSA.**

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

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

5. Did you change contribution amount?

Healthcare FSA monthly contribution	From: \$ _____ (minimum \$20)	To: \$ _____ (minimum \$20)
Dependent Care FSA monthly contribution	From: \$ _____ (minimum \$20)	To: \$ _____ (minimum \$20)

6. Spouse's FSA

Did you gain eligibility under your spouse's FSA? Yes No If yes, please complete the following information.

Plan Type:	<input type="checkbox"/> Healthcare FSA <input type="checkbox"/> Dependent Care FSA	
Spouse's Name	Employer	Effective Date _ _ / _ _ / _ _ _ _

7. Employee Signature and Authorization

I affirm that I am eligible to participate in the Healthcare FSA Dependent Care FSA and that my subject dependents meet related federal requirements. (review www.oregon.gov/DAS/PEBB/docs/SPD/DCFSA.pdf)

I understand that:

- An FSA is subject to federal government regulations.
- The elections I have made are in effect as long as PEBB eligibility and participation requirements are met.
- If I do not incur the anticipated expenses during the plan year or grace period, and I do not file for reimbursement by the end of the grace period, I 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 yearly 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