pebb
Public Employees' Benefit Board

Healthcare FSA Prepay Request

Office use only
Approved by: _____
Approved date: _____
Effective date: _____

Complete this form to request prepayment for a Healthcare Flexible Spending Account (FSA) before the beginning of your protected leave. See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml.

Submit the completed form to PEBB using one of the contact methods below.

Protected leave type *(Check one)*

☐ Family and medical leave act ☐ Active duty military leave ☐ Continued benefit of injured worker

Contact information *(You must complete all fields, please print.)*

PEBB benefit number (P########), OR#, University ID or Lottery ID

Last name	First name	Middle	Agency	Gender
				☐ M ☐ F

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

Contact address	☐ Check if new address	Apartment #	City	State	ZIP	County

Residence ZIP code	Work ZIP code	Work email	Personal email (optional)

Date of birth (mm/dd/yyyy)	Work phone	Home phone (optional)

Calculate your prepayment

(Calculate the full contribution to be made during your leave in the currect plan year.)

Expected leave — Number of months on leave

From: To:

Current monthly contribution $_____ X Number of months on leave _____ = **Total prepay needed*** $_____

Period for prepayment (must be paid before leave begins) — Number of months for prepayment

From: To:

Monthly contribution increase $_____ X Number of months for prepayment _____ = **Total prepay contribution*** $_____

*** Total prepay contribution amount must be equal to the total prepay needed amount.**

Employee signature and authorization

I understand that my request will not be processed without verification of leave approval from my agency.

I also understand that:

- Eligible expenses incurred during the approved leave will be eligible for reimbursement only if I prepay the contribution before the leave starts.
- If my participation terminates during the leave, requests for reimbursement incurred after the termination will not be eligible for reimbursement.
- The effective date of this request is the first of the month following receipt of this form by the agency.
- If I fail to report on this enrollment form a change that made an enrolled family member ineligible, PEBB may terminate the family member's coverage retroactively, pursuant to PEBB rules.

☐ I certify that I have read the information and meet the requirements as indicated.

Employee signature_____ Date_____

Send to: Public Employees' Benefit Board 500 Summer St NE, E89 Salem, OR 97301
Or Fax: 503 373-1654

Submit completed form to your agency payroll or university benefits office.

Keep a copy of your benefit forms for your records.