pebb
Public Employees' Benefit Board

Flexible Spending Account Midyear Change

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

See Summary Plan Description for more information at: www.oregon.gov/OHA/PEBB/Pages/spd.aspx

Effective Date is first of the month following receipt of this form by PEBB.

Contact information

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)

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.

☐ **I got married** Date:

HCFSA	Because of this event, I may:	☐ Enroll ☐ Increase
	Because I gained eligibility under my spouse's HCFSA, I may: (you must complete spouse info on page 4)	☐ Decrease
DCFSA	Because of this event, I may:	☐ Enroll ☐ Increase
	Because my spouse works a different shift, is disabled or is a full-time student, I may:	☐ Decrease ☐ Cancel
	Because I gained eligibility under my spouse's DCFSA, I may: (you must complete spouse info on page 4)	☐ Decrease ☐ Cancel

Midyear event information *(continued)*

☐ **I lost my spouse through divorce, annulment or death**		Date:
HCFSA	Because I lost coverage under my spouse's HCFSA plan, I may:	☐ Enroll ☐ Increase
	Because of this event, I may:	☐ Decrease
DCFSA	Because of this event, I may:	☐ Enroll ☐ Increase
	Because my dependent-care needs decreased, I may:	☐ Decrease
	Because I lost eligibility for a DCFSA, I may: (example: dependent now resides with ex-spouse)	☐ Cancel

☐ **I gained a dependent through birth, adoption, placement for adoption or affidavit (Dependent gains eligibility)**		Date:
HCFSA	Because of this event, I may:	☐ Enroll ☐ Increase
	Because my spouse enrolled in or increased contribution to an HCFSA, I may: (you must complete spouse info on page 4)	☐ Decrease ☐ Cancel
DCFSA	Because of this event, I may:	☐ Enroll ☐ Increase
	Because my spouse stopped working, I may:	☐ Cancel

☐ **I lost a dependent or my dependent lost eligibility**		Date:
HCFSA	Because of this event, I may:	☐ Decrease
DCFSA	Because of this event, I may:	☐ Decrease
	Because I no longer have eligible dependents, I may:	☐ Cancel

☐ **I changed work hours or returned to work from a leave of absence**		Date:
HCFSA	Because I returned from a leave of absence, I may:	☐ Enroll
DCFSA	I returned from a leave of absence, I may enroll only	☐ Enroll
	Because my dependent care needs increased, I may:	☐ Enroll ☐ Increase, consistent with the change in cost
	Because my dependent care needs decreased, I may:	☐ Decrease, consistent with the change in cost ☐ Cancel

Midyear event information *(continued)*

☐ **My spouse has a change in employment or terminated employment**		Date:
HCFSA	Because I lost coverage under my spouse's HCFSA plan, I may:	☐ Enroll ☐ Increase
	Because I gained eligibility under my spouse's HCFSA, I may:	☐ Decrease ☐ Cancel
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:	☐ Enroll ☐ Increase
	Due to loss of eligibility for coverage, I may:	☐ Decrease ☐ Cancel

☐ **Judgments, decrees or orders**		Date:
HCFSA	This requires me to:	☐ Increase ☐ Decrease
DCFSA	No changes allowed.	

☐ **Dependent care change in cost or coverage** Please select the reason for the change along with the change to your DCFSA		Date:
DCFSA	☐ Because a change to a new daycare provider increased costs, I may: ☐ Because my spouse's employer ceased to offer DCFSA, I may: ☐ Because my spouse revoked a DCFSA during a different open enrollment period than PEBB's, I may:	☐ Enroll ☐ Increase, consistent with the change in cost
	☐ Because my daycare provider increased costs, I may: ☐ Because I increased the salary of my household employee (not my relative) who provides dependent care, I may:	☐ Increase, consistent with the change in cost
	☐ Because my spouse enrolled in a new DCFSA, I may: ☐ Because my spouse changed to a self-employed arrangement, decreasing dependent care costs, I may: ☐ Because a change to a new daycare provider decreased costs, I may: ☐ Because my dependent entered school for the first time, I may:	☐ Decrease, consistent with the chance in cost ☐ Cancel

Did you enroll in an FSA?

If yes, enter your monthly contribution amount, multiply by the number of months remaining in the calendar year in which you will recieve a paycheck. This will be your total year election. NOTE: Effective date of changes are always prospective and are the first of the month following PEBB's receipt of this form. **Minimum monthly contribution is $20 per FSA.**

*University employees please check the months you will not receive a paycheck. ☐ June ☐ July ☐ August ☐ September

Did you enroll in an FSA? *(continued)*

	Monthly contribution (minimum $20)	Number of months remaining in current year you will be paid	Total year election
Healthcare FSA (Total year maximum = $2,650)	$_____ X	_____ =	$_____
Dependent Care FSA (Total year maximum = $5,000; $2,500 if you are married and file taxes separately)	$_____ X	_____ =	$_____

Did you gain eligibility under spouse? Please complete

Plan type: ☐ Healthcare FSA ☐ Dependent Care FSA

Spouse's name	Employer	Effective date
_____	_____	_____

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)

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 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.
Any alteration of this form may result in it being ineffective.