PacificSource ADMINISTRATORS

Employee Flexible Spending Account (FSA) Enrollment Form

1. Employment Information

Employer **Eugene School District 4J** Hire Date (required for mid-yr. enrollment) _____

PSA Member ID (if applicable) _____ Employee ID _____

NOTE: FSA benefits are effective on the first day of benefit eligibility; any deductions will be taken from your paycheck accordingly

2. Employee Information

Employee Last Name _____ First Name, MI _____

Birth Date _____ Social Security No. _____

Mailing Address _____ City _____ State _____ ZIP _____

Primary Phone _____ Secondary Phone _____

Email _____ Beneficiary Name and Relationship _____

3. Premium Payment Component

I understand that my salary will be reduced on a pretax basis to pay the premiums offered by my employer for medical and hospitalization insurance, major medical insurance, dental insurance, vision insurance, and/or other qualified benefits under Section 125 for myself and my eligible family members.

4. Flexible Spending Account Election

The plan year for all 4J benefits, including flexible spending accounts, runs from October 1, 2019 through September 30, 2020.

	Account (as offered)	Employee Pay Period Election	No. of Pay Dates	Employee Annual Election	Account Information
DCAP Component	Dependent Care Expenses (DCE)	$_____.___	X_____	=$_____	Childcare expenses (for dependents younger than 13) and elder care expenses you incur while at work or school.
Health FSA Component	General-Purpose Health FSA (HRE)	$_____.___	X_____	=$_____	Eligible medical, dental, vision, and preventive expenses for yourself and eligible dependents.

☐ Check here if you or your dependents are enrolled (or plan to enroll) in a health savings account.

Continued on reverse >

5. Member Information

Employer **Eugene School District 4J**

Employee _____

6. Optional Features

Optional features may not be available for all plans. See your plan summary or ask your employer for additional information. If available, you may elect the Benny™ Debit Card. If you are enrolled in your employer's PacificSource plan, you may be eligible for the EasyPay program. FSA claims may still be submitted via fax, mail, or electronically through our MyFlex website. **Select from the following choices (please circle one):**

Benny Debit Card	A Benny™ Prepaid Benefits Card deducts directly from your health FSA at the point of sale. Itemized receipts are required for all transactions that are not auto-substantiated at the point of sale. There is no additional cost for acquiring your initial Benny ™ Prepaid Benefits Cards. Upon expiration (5 years) a new set will be automatically mailed for no additional fee. *Select if you would like to enroll and/or remain enrolled, or disenroll.*	Enroll and/ or Remain Enrolled Disenroll
Replacement Benny Debit Card	A set of two replacement/additional Benny™ Prepaid Benefits Cards are available for a fee of $10. This fee is deducted from your health FSA account. Please indicate if your cards have been lost or stolen (and you would like to replace your cards with new numbers). Or indicate if you would like to order additional cards with the same card	Lost/Stolen Additional

7. Participant Authorization or Waiver

Participant Authorization

I hereby certify the information provided on this form is correct and true to the best of my knowledge, and that the children for whom I will be claiming dependent or childcare expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that Health Care FSA amount above $500 remaining in my account(s) or any amounts remaining in my Dependent Care Account not used for eligible expenses incurred during the Plan Year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the flexible compensation reductions will be in effect for the plan year and cannot be revoked unless I experience a qualified change in status. I also understand that the reductions may correspondingly reduce my future Social Security benefits.

If I lose coverage under the health FSA component as a result of a qualifying event (for example, termination of employment or cessation of eligibility because of a reduction in hours of employment), I may be entitled to elect coverage continuation under the health FSA allowed by my employer's Plan. I understand that I cannot be forced to repay or voluntarily repay the employer for any amounts exceeding my health FSA account balance.

Any person who, with an intent to knowingly defraud, files this application with materially falsified information or conceals material information, may be subject to criminal and civil penalties and PacificSource Administrators may cancel such person's membership and refuse to pay their claims.

Employee Signature***** _____ Date _____

Employee: *Please return the original to your employer and retain a copy for your records.*
Employer: *Please audit the form, retain a copy for your records, and forward a copy to PacificSource Administrators or submit a spreadsheet electronically.*

PacificSource Administrators PO Box 70168, Springfield, OR 97475; (541) 485-7488, (800) 422-7038;
fax (541) 225-3648, (800) 575-1109; PacificSource.com/PSA