



Health & Benefits

560 East 200 South, Salt Lake City, UT 84102

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PEHP FLEX\$

Salary Reduction Agreement

Name (First, Middle, Last)		PEHP ID #	Plan Year
Home Address	City	State	Zip
Daytime Phone			
Email Address		Employer	

SECTION A

Plan year begins July 1 and ends June 30. You must re-enroll in FLEX\$ each year. Minimum \$130 per plan year

Qualified Healthcare Account \$_____ per plan year Maximum \$2,700 per plan year
(Medical, dental, or vision out-of-pocket expenses for you, your spouse, or dependent children.)

Qualified Dependent Day Care Account \$_____ per plan year
(Day care expenses only for your dependent children.) Minimum \$130 per plan year, maximum \$5,000 per plan year. (\$2,500 if married and planning to file a separate IRS tax return).

Total Salary Reduction* \$_____ per plan year

* The salary reduction amount for health care and/or dependent day care will be divided by the number of pay periods per plan year. (Or the remaining number of paydays for the Plan Year). For mid-year changes, enter the total amount to be withheld for the Plan Year. (Cannot be less than year to date contributions).

SECTION B

<input type="checkbox"/> Open Enrollment Period Enroll by June 15 or the date specified by your employer for the following plan year <input type="checkbox"/> New Hire Employee hire date _____ * Mid-year changes/new hire enrollment must be made within 60 days of the qualifying event.	<input type="checkbox"/> Mid-Year Changes after July 1* Qualifying Event/Status Change Date _____ <input type="checkbox"/> Marriage <input type="checkbox"/> Spouse Employment Change <input type="checkbox"/> Divorce <input type="checkbox"/> Dependent Status Change <input type="checkbox"/> Death of Spouse or Child <input type="checkbox"/> Change in Daycare Needs <input type="checkbox"/> Birth or Adoption of Child <input type="checkbox"/> COBRA <input type="checkbox"/> Employment Status Change <input type="checkbox"/> Other _____ Explain in detail or attach appropriate documents: _____ _____
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SECTION C

With your enrollment, you automatically get one PEHP FLEX\$ Benefit Card. Complete the following to order an extra card for your spouse.

_____	_____	_____
Spouse Name	Spouse PEHP ID#	Spouse Birthdate

Before signing, make sure that all applicable sections are complete so your enrollment is not delayed. You may be asked to provide additional information and/or documentation.
 Please note: It is the employee's responsibility to notify PEHP within **60 days of any changes** effecting coverage and/or dependent eligibility (e.g., birth, marriage, divorce, etc.).
 I represent that all information is true and correct. I understand and agree that any false information I provide on this form may, at PEHP's sole discretion, result in a limitation or termination of my coverage. By signing below, I hereby: (1) authorize the deduction of health/dental contributions through the provisions of IRS Section 125 Flexible Benefits; (2) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health plan; (3) certify all dependents listed are eligible for coverage; (4) understand if PEHP is not notified that a dependent is ineligible and subsequent claims are paid, I will be responsible for reimbursement to PEHP for any claims paid in error; (5) certify that any expenses submitted are eligible expenses under Section 125(a) of the Internal Revenue Code; and (6) agree to the terms and conditions in the PEHP Master Policy.

_____	_____	PEHP Approval
Employee Signature	Date	