PEHP
Health & Benefits
560 East 200 South, Salt Lake City, UT 84102
801-366-7503 / 800-753-7703 | **FAX:** 801-366-7772 / **Toll-free FAX:** 800-759-8772

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

Maximum **$2,850** per plan year

Qualified Healthcare Account

$_____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

☐ Open Enrollment Period
Enroll by the date specified by your employer for the following plan year

☐ New Hire
Employee hire date_____

* Mid-year changes/new hire enrollment must be made within 60 days of the qualifying event.

☐ **Mid-Year Changes after July 1***

Qualifying Event/Status Change Date_____

☐ Marriage
☐ Divorce
☐ Death of Spouse or Child
☐ Birth or Adoption of Child
☐ Employment Status Change
☐ Spouse Employment Change
☐ Dependent Status Change
☐ Change in Daycare Needs
☐ COBRA
☐ Other_____

Explain in detail or attach appropriate documents:_____

_____

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.

_____ _____
Employee Signature Date

PEHP Approval

Consult your tax advisor for any tax advice concerning your plan(s).