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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 September 1 and ends August 31.

You must re-enroll in FLEX\$ each year.

Minimum \$130
per plan year

Qualified Healthcare Account

\$_____ per plan year

(Medical, dental, or vision out-of-pocket expenses for you, your spouse, or dependent children.)

Maximum \$2,700
per plan year

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 August 15 or 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 September 1*

Qualifying Event/Status Change Date_____

☐ Marriage

☐ Spouse Employment Change

☐ Divorce

☐ Dependent Status Change

☐ Death of Spouse or Child

☐ Change in Daycare Needs

☐ Birth or Adoption of Child

☐ COBRA

☐ Employment Status Change

☐ 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