

PEHP FLEX\$
Salary Reduction Agreement

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

	Name (First, Middle, Last)	PEHP ID #			Plan Year		
					20	24-25	
	Home Address Cit	ty State Zip Employer			Daytime Phone		
	Email Address						
	Plan year begins July 1 and ends June 30.	You must re-enroll in FL			per plan year		
	Qualified Healthcare Account			pe			
	(Medical, dental, or vision out-of-pocket expenses	s for you, your	spouse, or depe	endent children.)		per plan year	
	Qualified Dependent Day Care Acco	\$	per plan year				
350101	(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*		\$	pe	r 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).						
	Open Enrollment Period  Enroll by June 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  Qualifying Event/Status Change Da  Marriage Divorce Death of Spouse or Child Birth or Adoption of Child Employment Status Change  Explain in detail or attach appropri		nange Date	·		
	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						
)	Spouse Name		use renr ID#		Spouse I	on tritate	
	efore 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 commentation.  ease 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, cc.).  epresent 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 of the endity of the provisions of IRS Section 125 Flexible enefits; (2) authorize PEHP to release information to health/dental providers, insurance entities, or other entities necessary to process claims and to administer the health an; (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 esponsible 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 odde; and (6) agree to the terms and conditions in the PEHP Master Policy.						
				PEHP Approval			
	Employee Signature	Date					