PEHP
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

State of Utah

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 **$2,550** for the 2015 Plan Year. IRS maximum may change each 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 June 15

☐ 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

I hereby authorize my employer to reduce my gross salary in the amounts designated above and contribute the amounts to the designated FLEX$ account(s). I agree to contribute the amount designated per pay period to cover this annual elected total. I promise and agree to repay the administrator for all amounts paid in excess of that which I have elected. I acknowledge that the salary reduction amount will not exceed my gross salary for that same period. Should a deduction fail to be made, on the pay period following the effective date, I will contact the Plan Administrator no later than the next pay period. Failure to take such corrective action will cancel my participation for the remainder of the current Plan Year.I acknowledge and understand that the deduction reflected herein is irrevocable, except as provided for in the respective Plan Handbook (available at www.pehp.org) which I have received and read. I acknowledge that the Plan Administrator shall pay or reimburse approved expenses from the appropriate account(s) up to the maximum annual elected amount. Any amounts in my account(s) not properly claimed or used by me shall be forfeited to my employer. I certify that the dependents for whom I will submit claims are eligible dependents according to Section 125 (a) of the IRS Code. I also certify that any expenses paid, using the administrator issued Flex Spending Card, will be for eligible medical expenses for myself, my spouse and/or my eligible dependents and that such expenses have not and will not be reimbursed under any other Flexible Spending Plan, insurance plan or claimed as a deduction on a tax return. I authorize PEHP and affiliated organizations to release personal information, including personal health information, about me, my spouse and/or my dependents, as necessary to process claims and to administer the 125 Flexible Benefit Plan.

_____ Employee Signature

_____ Date

PEHP Approval