

**Public Employee's Health Program, FLEX\$ Enrollment**

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**Dixie ATC**

**FLEXIBLE REIMBURSEMENT ACCOUNT**

**PROGRAM (FLEX\$)**

**SALARY REDUCTION AGREEMENT**

Name (First, Middle, Last)	ID#	<b>PLAN YEAR:</b>
Home Address	City State Zip	Daytime Phone
IF you would like FLEX\$ enrollment verification, please provide your E-mail address* E-mail:*		Agency/Dept

\* E-mail address will be used by PEHP for FLEX\$ verification **ONLY**. Please allow 5 business days for verification.

**SECTION A - SALARY REDUCTION INFORMATION**

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

**Qualified Health Care Account** \$ \_\_\_\_\_ Per Plan Year  
 (Medical, dental, or vision out of pocket expenses for you, your spouse, or dependent children.) Minimum \$130 per plan year: Maximum \$5,000 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 - ENROLLMENT INFORMATION**

<input type="checkbox"/> Open Enrollment Period  Enroll by May 31 for the following plan year	<input type="checkbox"/> <b>Mid-Year Changes After July 1*:</b> Qualifying Event/Status Change Date: _____									
	<table border="0"> <tr> <td><input type="checkbox"/> Marriage</td> <td><input type="checkbox"/> Employment Change of Spouse</td> </tr> <tr> <td><input type="checkbox"/> Divorce</td> <td><input type="checkbox"/> Dependent Status Change</td> </tr> <tr> <td><input type="checkbox"/> Death of Spouse or Child</td> <td><input type="checkbox"/> Change in Day Care Needs</td> </tr> <tr> <td><input type="checkbox"/> Birth or Adoption of Child</td> <td><input type="checkbox"/> Cobra</td> </tr> <tr> <td><input type="checkbox"/> Employment Status Change</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Marriage	<input type="checkbox"/> Employment Change of Spouse	<input type="checkbox"/> Divorce	<input type="checkbox"/> Dependent Status Change	<input type="checkbox"/> Death of Spouse or Child	<input type="checkbox"/> Change in Day Care Needs	<input type="checkbox"/> Birth or Adoption of Child	<input type="checkbox"/> Cobra	<input type="checkbox"/> Employment Status Change
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<input type="checkbox"/> Birth or Adoption of Child	<input type="checkbox"/> Cobra									
<input type="checkbox"/> Employment Status Change	<input type="checkbox"/> Other _____									
<input type="checkbox"/> New Hire  Employee hire date _____	Explain in detail or attach appropriate documents: _____ _____									

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

**SECTION C - SPOUSE CARD INFORMATION**

With your enrollment in a FLEX\$ Health Plan you will automatically receive one PEHP FLEX\$ Benefit Card. Please complete the following to order an additional card for your spouse.

\_\_\_\_\_ Spouse Name                      \_\_\_\_\_ Spouse ID#                      \_\_\_\_\_ Birth Date

**SECTION D - ELECTION AUTHORIZATION AND ACKNOWLEDGMENT**

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](http://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 152(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's Signature	Date	PEHP Approval
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