Public Employees Health Program, HSA Accounts
560 East 200 South, Suite 100, Salt Lake City, Utah 84102-2004
801-366-7503 TOLL FREE 800-753-7703
FAX 801-366-7772 TOLL FREE 800-759-8772

State of Utah

HSA Benefit Card Agreement
Limited FSA Enrollment Form

PLAN YEAR FROM JULY 1 TO JUNE 30

EMPLOYEE INFORMATION		
EMPLOYEE NAME (last, first, middle initial)	SSN#	**PLAN YEAR:**
HOME ADDRESS CITY/STATE/ZIP		DAYTIME PHONE
Employee High Deductible Health Plan (HDHP) Enrollment Date:		Email:

HEALTH SAVINGS ACCOUNT ELECTION

FUTURE HSA CONTRIBUTIONS FROM MY SALARY (optional)	Amount
Total amount to be withheld per pay period, beginning the next possible pay period	

Limited Purpose FSA Card Agreement

☐ **Send me a LFSA Benefit Card**

The first two cards are free. All additional cards are $10 each.

Additional Cards (Limited FSA)

Designation	Full Given Name of Eligible Person	Send Card
Spouse		☐
Dependent		☐

LIMITED FSA ELECTION

	Per pay period
Qualified Limited FLEX$ Account	$
Qualified Dependent Day Care Account	$

New Hire *

Employee Hire Date: _____

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
Employment Change of Spouse
Dependent Status Change
Other

Explain in detail or attach appropriate Documents: _____

_____

_____

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

Benefit Card Agreement

I hereby, authorize my employer to reduce my gross salary in the amounts designated above and contribute the amounts to the designated HSA and/or limited FLEX$ account. I agree to contribute the amount designated per pay period to cover this election amount. 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 in the limited FSA for the remainder of the current Plan Year. I acknowledge and understand that the deduction reflected here in 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 Limited FSA account 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 dental and vision 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, HSA, HRA or claimed as a deduction on a tax return. I understand that if I have an HSA, my limited FSA can be used for preventative, dental and vision services only. I understand that to participate in the Limited FSA, I must be enrolled in a HDHP and HSA.

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

Unsigned claims will not be processed.