PEHP Health & Benefits
560 East 200 South, Salt Lake City, UT 84102
801-366-7555 / 800-765-7347
Fax: 801-366-7599
www.pehp.org

State Risk Pool
Enrollment and Change Form

This form applies to the following employers only:

- Davis Technical College
- Heber Valley Historic Railroad
- MIDA
- Mountainland Technical College
- Ogden-Weber Technical College
- Snow College
- Tooele Technical College
- UFAIR
- Uintah Basin Technical College
- URS/PEHP
- Utah Communications Authority
- Utah Housing Corporation
- Utah Inland Port Authority
- Utah Safety Council
- Utah State Fair Corporation
- Utah State University-Eastern
- Weber State University

Changes made on this form are for medical, dental, and vision only.
Please print clearly.

Employee Status		**Benefit Eligibility**	
☐ Full time	☐ Part time	☐ Eligible	☐ Ineligible

☐ New Enrollment ☐ Termination ☐ Change Request (Please Specify Type):_____

YOUR NAME (last, first, middle initial)	SOCIAL SECURITY NUMBER	BIRTH DATE (mm/dd/yy)	MARITAL STATUS ☐ SINGLE ☐ MARRIED	GENDER ☐ MALE ☐ FEMALE
MAILING ADDRESS	CITY/STATE/ZIP	PRIMARY PHONE		
EMPLOYER	EMAIL ADDRESS	ALTERNATE PHONE	HIRE DATE (mm/dd/yy)	

Group Medical (check one) | ***Check with your employer to see which options are available to you***

Coverage type (Check one)

- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus two or more dependents
- ☐ No medical coverage at this time

Choose your network

- ☐ Summit Network
- ☐ Advantage Network

Choose your medical plan

- ☐ STAR HSA (complete below for HSA eligibility)*
- ☐ Traditional
- ☐ Consumer Plus (complete below for HSA eligibility)*
  Only available to new hires and members previously enrolled in STAR HSA.
- ☐ Opt-Out of Medical Coverage
  You must have other qualified employer-sponsored coverage to opt-out. See Employee Agreement at bottom of the form.

* For STAR HSA or Consumer Plus enrollment, confirm HSA eligibility.

- ☐ I am eligble for a Health Savings Account (HSA)
- ☐ I am not eligible for a Health Savings Account (HSA). If offered by your employer, you will be enrolled in a Health Reimbursement Account (HRA).

GROUP DENTAL (Check one)

- ☐ PEHP Preferred Dental
- ☐ PEHP Traditional Dental
- ☐ EMI Choice Indemnity
- ☐ No dental coverage at this time
- ☐ Opt-Out of Dental Coverage
  You must have other qualified employer-sponsored coverage to opt-out. See Employee Agreement at bottom of the form.

Coverage type (Check one)

- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus 2+ dependents

VISION (Check one)

- ☐ Eyemed – Full
- ☐ Eyemed – Eyewear Only
- ☐ No vision coverage at this time

Coverage type (Check one)

- ☐ EMPLOYEE ONLY
- ☐ Employee plus one dependent
- ☐ Employee plus 2+ dependents

ADDITIONS List your eligible dependents. For your spouse, include a copy of marriage certificate. For dependent children enrolled, include a copy of birth certificate. If dependents are classified as Other Relationship, please provide supporting documentation, e.g., court orders, birth certificates, etc. PEHP benefits will not be processed until required documentation is received.

RELATIONSHIP TO EMPLOYEE		FULL NAME OF DEPENDENTS (last, first, middle initial)	MARRIAGE DATE (mm/dd/yy)	GENDER	BIRTH DATE (mm/dd/yy)	DEPENDENT SOCIAL SECURITY NO.	COVERAGE DESIRED
CODE KEY: **S »** Legal Spouse **C »** Child Natural/ Adopted **SC »** Stepchild **O »** Other (Describe in Section D)	**S**			☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision
				☐ **Male** ☐ **Female**			☐**M**edical ☐**D**ental ☐**V**ision

Are you, your spouse, or dependents covered by any other health or dental plan or by Medicare? ☐ **Yes** ☐ **No** **If yes, complete Multiple Group Coverage Section on back.**

Signature required on other side.

(HR use only) **SRP-E** 7-10-25

Effective Date:_____ Employment Termination Date:_____ Coverage Termination Date:_____ HR Approval:_____

Page 2: State Risk Pool | Enrollment and Change Form

Employee Name: _____ Social Security Number: _____

REMOVALS Fill out the table below if you are terminating coverage for dependents who are no longer eligible. For all terminations outside of annual enrollment, adequate documentation is required (divorce decree, proof of other coverage, etc.) If you voluntarily drop dental coverage, you will not be able to re-enroll for up to three years.

RELATIONSHIP TO EMPLOYEE		FULL NAME OF DEPENDENTS (last, first, middle initial)	DEPENDENT SOCIAL SECURITY NO.	REASON FOR TERMINATION (e.g., marriage, divorce, death, age of 26)	APPLICABLE DATE*	COVERAGE TERMINATED
S » Legal Spouse						☐**M**edical ☐**D**ental ☐**V**ision
C » Child Natural/ Adopted						☐**M**edical ☐**D**ental ☐**V**ision
SC » Stepchild						☐**M**edical ☐**D**ental ☐**V**ision
O » Other (Describe in Section D)						☐**M**edical ☐**D**ental ☐**V**ision

*Applicable Date is the date of marriage, divorce, birthday, etc.

Multiple Group Coverage

Complete if you, your spouse, or dependents are covered by any other health or dental plan sponsored by an employer or Medicare.

INSURANCE COMPANY/HMO & PHONE NO.	NAME OF POLICY HOLDER	POLICY HOLDER SSN OR POLICY NO.	EFFECTIVE DATE (mm/dd/yy)	TYPE OF COVERAGE	TYPE OF POLICY	MEDICARE	EMPLOYEE/DEPENDENTS COVERED BY PLAN (Only first name is needed)
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	
				☐ **Health** ☐ **Dental**	☐ **Employee** ☐ **Retired**	☐ **A** ☐ **A&B**	

Explanations

Employee Agreement and Signature

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) agree to the terms and conditions in the PEHP Master Policy.

Opting-Out of Coverage to Receive Cash-in-Lieu of Benefits: Employee understands and acknowledges that in order to be eligible to receive a cash-in-lieu-of-benefits option, employee is required to be continuously employed with employer and maintain other employer-sponsored insurance coverage during the next plan year. Employee may not opt out of PEHP coverage to receive cash-in-lieu of benefits if the only coverage they would have left is Medicaid, Medicare, or Individual Coverage through the Federal Marketplace. As part of the below agreement, employee also agrees that if employee elects to waive coverage and instead receive cash-in-lieu-of-benefits: 1) during the open enrollment period, employee shall provide an attestation of other employer-sponsored coverage (or provide PEHP with a certificate of coverage from the other employer-sponsored insurance company); and 2) employee shall inform PEHP immediately upon the loss or termination of other coverage. Failure to meet these obligations will result in forfeiture of cash-in-lieu-of-benefits and may result in the employee having to repay the cash-in-lieu of benefits to your employer and facing penalties for perjury. If an employee elects to waive coverage, but does not provide the attestation or the certificate of coverage during the open enrollment period, employee's coverage will be waived but employee will not receive any cash-in-lieu of benefits. If an employee elects to waive dental coverage, the employee will be eligible to re-enroll in a PEHP dental plan only if the employee has proof of other dental coverage or at least three years have passed since the employee waived PEHP dental coverage.

In order to receive cash-in-lieu of benefits, an employee must waive coverage and complete the following attestation. (1) I am over 18 years of age and I am providing this Attestation to show my eligibility to receive cash-in-lieu of participation in the PEHP medical and/or dental plans (the "Plan"). (2) Under penalty of perjury, I solemnly swear and affirm that the information provided below is true and correct. I understand that if such information is not true and correct, it may constitute insurance fraud, and may result in termination of benefits and criminal penalties. I agree to keep PEHP updated on any changes to my other employer-sponsored insurance coverage at all times. I further understand that adequate documentation of other employer-sponsored insurance coverage may be requested and that if I am unable to produce documentation to verify adequate coverage, my cash-in-lieu of benefits will be terminated retroactively to the time my other coverage ceased, and I will be fully responsible to repay my employer for all amounts I received, including any recovery costs, for any amounts paid by the plan for ineligible cash-in-lieu of benefits payments. (3) I attest that I and all of my dependents eligible for PEHP health and/or dental coverage have previously been and are currently covered under other employer-sponsored health and/or dental insurance which meets the standards for minimum essential coverage. I acknowledge and understand that Medicaid, Medicare, or Individual Coverage through the Federal Marketplace are not considered employer-sponsored insurance coverage and are not employer-sponsored insurance coverage.

☐ I certify that I am not a party to a divorce proceeding and am not subject to an injunction/order which prevents me from modifying insurance or changing beneficiaries.

Employee Signature	Date

Please make a copy for your records.

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

Flex Spending Accounts

Plan year begins July 1 and ends June 30.

You must re-enroll in FLEX$ each year.

SECTION A

If Enrolling in Traditional Medical Plan, or Opt Out Medical Coverage:

Qualified Healthcare Account

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

Minimum **$130 per** plan year
Maximum **$3,300** per plan year

$_____ per plan year

If Enrolling in STAR HSA or Consumer Plus Medical Plan:

Limited Purpose Flex Account

1. Verify if your employer offers this benefit.
2. You can only enroll in a Limited FSA if you have a HDHP with an HSA.
3. If you do not have an HDHP with an HSA, you will enroll in a regular FSA.

Minimum **$130 per** plan year
Maximum **$3,300** per plan year

$_____ 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).

☐ I certify I have a dependent child or children in Daycare and acknowledge that the DCA account is for reimbursement of Qualified Daycare Services rendered for my dependent(s) up to age 13, and by a Qualified Daycare Provider.

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 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 30 or 60 days of the qualifying event, depending on your employer's enrollment policy.

☐ **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

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

PEHP, HSA Accounts
560 East 200 South, Suite 100, SLC, UT 84102
801-366-7503 FAX 801-366-7772

State Risk Pool

HSA Enrollment

ONLY REQUIRED IF ENROLLING IN THE STAR HSA OR CONSUMER PLUS MEDICAL PLANS

Section 1: HSA ELIGIBILITY CHECKLIST – PLEASE REVIEW

To determine your eligibility, please review the statements below. If any apply to you, then you are not eligible for a health savings account. For the complete IRS rules about HSA eligibility, please visit http://www.irs.gov/publications/p696/ar02.html.

- ☐ I am covered by another health plan (unless it is another HSA-qualified plan).
- ☐ I am covered by Medicare.
- ☐ I am the dependent of another taxpayer.
- ☐ I am participating in or covered by an HRA or flexible spending account (FSA), and the balances will be greater than $0 after the last day of the plan year.

I have reviewed the eligibility requirements and I have determined that:

- ☐ Yes, I am eligible for a Health Savings Account. None of the statements above are applicable to me.
- ☐ No, I am not eligible for a Health Savings Account.
- ☐ I understand that I will receive my employer contribution in a Health Reimbursement Account (HRA).

Section 2: HSA EMPLOYEE CONTRIBUTIONS

You are allowed to make personal payroll contributions to your Health Savings Account. For 2025, you can contribute:

» Up to $4,300 if on a single plan » Up to $8,550 if on a double/family plan

I would like to contribute: $ _____ Per Pay Period

AUTHORIZATION

I hereby authorize my employer to reduce my gross salary in the amount designated above and contribute the amounts to my designated health savings account. I acknowledge that the salary reduction amount will not exceed my gross salary for that same period.

Employee Signature	Date	PEHP Approval