State of Connecticut
Dependent Care Assistance Program

Flexible Spending Account Benefit Enrollment/Change Election Form

Rev.10/2006

Group No. _____

SECTION I – PARTICIPANT INFORMATION

PARTICIPANT (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	EMPLOYEE NUMBER	MARITAL STATUS ☐ Single ☐ Married
HOME ADDRESS (Street Address)	(City, State, Zip Code)		HOME PHONE NO.
NAME OF EMPLOYING AGENCY	DEPARTMENT ID	DATE OF HIRE	OFFICE PHONE NO.

LIST DEPENDENTS TO BE COVERED

Relationship	First Name, Middle Initial, Last Name	Social Security	Sex	Date of Birth Month	Day	Year

SECTION II – BENEFIT ELECTIONS

OPEN ENROLLMENT ELECTION

Dependent Care Total Annual Election $_____
Dependent Care (maximum $5,000 if you are single, or married and filing a joint income tax return; maximum $2,500 if you are married and filing an individual tax return)

Amount Per Pay Period $ _____
Divide by number of pay periods in the Plan year (January 1 to December 31)

MID-YEAR ENROLLMENT/CHANGE ELECTION

The Employee/ Family Status Change that occurred is (check one):
☐ New Hire ☐ Marriage ☐ Divorce ☐ Adoption ☐ Birth ☐ Death ☐ Spouse Employment Change
☐ Spouse Employment Ended ☐ Other _____
Hire Date/ Family Status Date Change occurred: ___ ___ /___ ___ /___ ___

Original Annual Election: $_____ **Revised Annual Election: $ _____**
Present Amount Per Check $_____ **Revised Amount Per Check $ _____**

SECTION III – EMPLOYEE SIGNATURE

I acknowledge that my enrollment in the Dependent Care Assistance Program may reduce my financial participation in the Deferred Compensation (Section 457), Tax Sheltered Annuities (Section 403(b)), Social Security Entitlement and/or Retirement Benefit Plans. I further acknowledge that my participation in the Dependent Care Assistance Program is in accordance with all applicable Federal Laws and IRS Regulations.

A new employee may elect to participate within 31 days after his or her hire date.

This election form will remain in effect and cannot be revoked or changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of a child, termination of employment of spouse, etc.). **Any changes to your election must be made within 31 days of your change in family status.*

Changes will be processed on the check date following receipt of the change form pursuant to the Payroll Cut-off Date Schedule.

AUTHORIZATION I certify the above information to be correct and true and any dependents for which I have selected the dependent care benefit reside with me in a parent-child relationship and/or are legally dependent on me for their support. **I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws.**

_____ _____
Employee Signature Date(MM/DD/YYYY)

OFFICIAL USE ONLY

EFFECTIVE DATE: ___ ___ /___ ___ /___ ___ DATE OF PAYCHECK CONTRIBUTION: ___ ___/___ ___/___ ___

MAKE A COPY FOR YOUR RECORDS