

**State of Connecticut
Dependent Care Assistance Program
Enrollment/Change Form
Revised 09/10**



EMPLOYEE NAME (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER	EMPLOYEE NUMBER	EMPLOYEE RECORD NUMBER									
HOME ADDRESS (<input type="checkbox"/> Check if new address)			CITY, STATE, ZIP CODE										
NAME OF EMPLOYING AGENCY		DEPARTMENT ID	DATE OF HIRE										
EMAIL ADDRESS	DAYTIME CONTACT NUMBER		PAYROLL FREQUENCY <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly										
<input type="checkbox"/> OPEN ENROLLMENT ELECTION Annual Election Amount \$ _____ Amount Per Pay Period \$ _____ (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) Divide the number of pay periods in the Plan year (January 1 to December 31. Ex. Biweekly – 26 pays, Semi-monthly – 24 pays, Monthly – 12 pays)													
<input type="checkbox"/> MID-YEAR ENROLLMENT/CHANGE ELECTION <table border="1"> <tr> <td rowspan="5"> The Family Status Change that occurred is (check one): <input type="checkbox"/> New Hire <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Adoption <input type="checkbox"/> Birth <input type="checkbox"/> Death <input type="checkbox"/> Spouse Employment Change (Loss/Gain) <input type="checkbox"/> Other _____ </td> <td>Original Annual Election</td> <td>\$ _____</td> </tr> <tr> <td>Revised Annual Election</td> <td>\$ _____</td> </tr> <tr> <td>Present Amount Per Check</td> <td>\$ _____</td> </tr> <tr> <td>Revised Amount Per Check</td> <td>\$ _____</td> </tr> </table>					The Family Status Change that occurred is (check one): <input type="checkbox"/> New Hire <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Adoption <input type="checkbox"/> Birth <input type="checkbox"/> Death <input type="checkbox"/> Spouse Employment Change (Loss/Gain) <input type="checkbox"/> Other _____	Original Annual Election	\$ _____	Revised Annual Election	\$ _____	Present Amount Per Check	\$ _____	Revised Amount Per Check	\$ _____
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	Revised Annual Election	\$ _____											
	Present Amount Per Check	\$ _____											
	Revised Amount Per Check	\$ _____											

I hereby authorize the State of Connecticut to reduce my gross salary before federal, state and Social Security taxes are withheld by the total annual election amount elected above and affirm my understanding that:

- A new employee may elect to participate within 31 days after his or her hire date.
- My election is irrevocable and can not be changed during the plan year, unless I experience a qualifying change in family status, as defined by the Internal Revenue Code Section 129 (e.g., marriage, divorce, death of spouse or child, birth or adoption of a child, termination of employment of spouse, leave of absence, etc.). **Any election changes must be made within 31 days of a family status change.*
- Changes will be processed on the check date following receipt of the Enrollment/Change form pursuant to the Payroll Cut-off Date Schedule.
- Money in the DCAP account may only be used to reimburse expenses for DCAP eligible expenses actually incurred during the plan year.

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 certify that I will not deduct on my tax returns any expenses reimbursed by my DCAP and that I will collect and maintain documentation for claim substantiation. **I understand that any amounts remaining in my DCAP account that have not been used for eligible expenses incurred during the plan year (January 1 – December 31) must be claimed by March 31 of the following year or they will be forfeited in accordance with plan provisions and Internal Revenue Code requirements.**

Employee Signature _____ Date _____

KEEP A COPY FOR YOUR RECORDS

MAIL OR FAX COMPLETED FORM TO: Progressive Benefit Solutions, LLC (PBS), 23 Maiden Lane, North Haven, CT 06473
FAX: (203) 234-1139 Phone: 1-866-906-8023