



# State of Connecticut

## Dependent Care Assistance Program

### Benefit Enrollment/Change Form

Revised 11/09

MAIL OR FAX COMPLETED FORM TO:  
 Progressive Benefit Solutions, LLC (PBS)  
 23 Maiden Lane  
 North Haven, CT 06473  
 FAX: (203) 985-1717  
 Phone: 1-866-906-8023

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 BIRTH	
EMAIL ADDRESS	DATE OF HIRE	HOME PHONE NO.	OFFICE PHONE NO.	

DEPENDENTS TO BE COVERED						
Relationship	First Name, Middle Initial, Last Name	Social Security No.	Sex	Date of Birth		
				Month	Day	Year

**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)

**MID-YEAR ENROLLMENT/CHANGE ELECTION**  
 The Family Status Change that occurred is (check one):

New Hire     Marriage     Divorce     Adoption     Birth     Death     Spouse Employment Change

Spouse Employment Ended     Other \_\_\_\_\_

Original Annual Election \$ \_\_\_\_\_ Revised Annual Election \$ \_\_\_\_\_  
 Present Amount Per Check \$ \_\_\_\_\_ Revised Amount Per Check \$ \_\_\_\_\_

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, leave of absence, 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 (January 1 – December 31) and claimed by March 31 of the following year will be forfeited in accordance with current plan provisions and tax laws.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**MAKE A COPY FOR YOUR RECORDS**