# DEPENDENT CARE ASSISTANCE PROGRAM
# 2018 MID-YEAR ENROLLMENT OR STATUS CHANGE

DCAP
CO-1310a (Rev. 8/2017)

**Office of the State Comptroller**
**Healthcare Policy & Benefit Services Division**

**EMPLOYEE INFORMATION**

| | | |
|---|---|---|
| **Employee Name (last, first, middle initial)** | **Employee Number** | **Job Record Number** |
| **Street Address** | **Date of Birth** | **Social Security Number (must be provided)** |
| **City, State, Zip Code** | **Date of Hire** | ____ / ____ / ____ |
| **Employee Personal Email** | **Office Telephone No.** | **Home Telephone No.** |
| **Gender** ☐ **Male** ☐ **Female** | **Marital Status** ☐ **Single** ☐ **Married** | |

**ELIGIBILITY**

**You CANNOT enroll in the Dependent Care Assistance Program if you are:**

- On unpaid leave for any reason
- Adjunct faculty or graduate
- Working or expected to work less than 0.5 full time equivalent (0.5 FTE)
- Per Diem, sessional, durational, temporary or seasonal status
- Former employees and rehired retirees

**ENROLLMENT INFORMATION**

**(Please check applicable event)**

☐ New Hire ☐ Return from leave ☐ Marriage

☐ Divorce ☐ Spouse's employment change

☐ Death ☐ Birth ☐ Adoption ☐ Other

Explain _____

**Annual Election Amount** **$** _____

Minimum $520 / Maximum $5,000

($2,500 maximum for married, filing separately)

**I am paid on the following Payroll Cycle:**

☐ Bi-weekly (26) ☐ Semi-Monthly (24)

☐ Monthly (12) ☐ Five Pay (5)

**AUTHORIZATION**

I certify that the above information is true and correct and that any dependents for whom I have selected the DCAP benefit reside with me in a parent-child relationship and/or are legally dependent on me for their support. I understand that I cannot deduct expenses reimbursed by my DCAP on my federal tax return. I will retain documentation for claim substantiation.

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

- My election cannot be changed during the plan year, unless I experience a qualifying change in family status, as defined by the Internal Revenue Code Section 125. *Any election changes must be made within 31 days of the qualifying event.*
- Funds in the DCAP account may only be used to reimburse me for eligible expenses incurred during the plan year.
- **Funds in my DCAP account that are not claimed by March 31, 2019 for eligible plan year expenses will be forfeited in accordance with Internal Revenue Code requirements.**

| **Employee Signature** | **Date** |
|---|---|
| | |

**MAIL, EMAIL OR FAX COMPLETED FORM TO:**

**Progressive Benefit Solutions, LLC (PBS)**
14 Business Park Drive #8, Branford, CT 06405
Phone 1-866-906-8023 or 203-985-1712
**FAX: 203-974-4898**
**Email: Enrollment@pbscard.com**