



State of Connecticut

Dependent Care Assistance Program

Benefit Enrollment/Change Form

Revised 09/09

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, 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