

**DEPENDENT CARE ASSISTANCE PROGRAM
MID-YEAR ENROLLMENT OR STATUS CHANGE**

DCAP
CO-1310A (Rev. 1/2020)

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
ELIGIBILITY	<p align="center">You CANNOT enroll in the Dependent Care Assistance Program if you are:</p> <ul style="list-style-type: none"> ● On paid or unpaid leave for any reason ● Adjunct faculty or graduate assistant ● 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	<p>(Please check applicable event)</p> <input type="checkbox"/> New Hire <input type="checkbox"/> Return from leave <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Spouse's employment change <input type="checkbox"/> Death <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other Explain _____		<p>Annual Election Amount \$ _____</p> <p>Minimum is \$520: Maximum is \$5,000</p> <p>Married filing separately Maximum is \$2500</p>
	<p>I am paid on the following Payroll Cycle: <input type="checkbox"/> Bi-weekly (26) <input type="checkbox"/> Special Bi-weekly (26) <input type="checkbox"/> Semi-Monthly (24)</p> <p align="center"><input type="checkbox"/> Monthly (12) <input type="checkbox"/> Five Pay (5)</p>		
AUTHORIZATION	<p>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.</p> <p>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 indicated above and affirm my understanding that:</p> <ul style="list-style-type: none"> ● 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. <i>Any election changes must be made within 31 days of the qualifying event.</i> ● Funds in the DCAP account may only be used to reimburse me for eligible expenses incurred during the plan year. ● Unspent funds in my DCAP account that are not claimed by March 31, 2021 for eligible plan year expenses will be forfeited in accordance with Internal Revenue Code requirements. 		
Employee Signature		Date	

MAIL 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