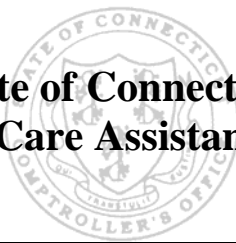


**State of Connecticut  
Dependent Care Assistance Program**



**Flexible Spending Account  
Benefit Enrollment/Change  
Election Form**

Rev.10/2006

Group No. \_\_\_\_\_

**SECTION I – PARTICIPANT INFORMATION**

PARTICIPANT (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	EMPLOYEE NUMBER	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married
HOME ADDRESS (Street Address)	(City, State, Zip Code)		HOME PHONE NO.
NAME OF EMPLOYING AGENCY	DEPARTMENT ID	DATE OF HIRE	OFFICE PHONE NO.

**LIST DEPENDENTS TO BE COVERED**

Relationship	First Name, Middle Initial, Last Name	Social Security	Sex	Date of Birth		
				Month	Day	Year

**SECTION II – BENEFIT ELECTIONS**

**OPEN ENROLLMENT ELECTION**

**Dependent Care Total Annual Election** \$ \_\_\_\_\_ **Amount Per Pay Period** \$ \_\_\_\_\_  
 Dependent Care (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 by number of pay periods in the Plan year (January 1 to December 31)

**MID-YEAR ENROLLMENT/CHANGE ELECTION**

**The Employee/ Family Status Change that occurred is (check one):**  
 New Hire  Marriage  Divorce  Adoption  Birth  Death  Spouse Employment Change  
 Spouse Employment Ended  Other \_\_\_\_\_  
**Hire Date/ Family Status Date Change occurred:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Original Annual Election:** \$ \_\_\_\_\_ **Revised Annual Election:** \$ \_\_\_\_\_  
**Present Amount Per Check** \$ \_\_\_\_\_ **Revised Amount Per Check** \$ \_\_\_\_\_

**SECTION III – EMPLOYEE SIGNATURE**

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 will be forfeited in accordance with current plan provisions and tax laws.**

Employee Signature \_\_\_\_\_ Date(MM/DD/YYYY) \_\_\_\_\_

**OFFICIAL USE ONLY**

EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE OF PAYCHECK CONTRIBUTION: \_\_\_\_/\_\_\_\_/\_\_\_\_