

DEPENDENT CARE ASSISTANCE PLAN ENROLLMENT FORM FY_____

Section A – Type of Enrollment

Benefits Choice Enrollment

New Hire Date of Hire ____ / ____ / _____

Mid-Year Enrollment **Qualifying Change in Status Code Required** (see chart in Section D) _____

I certify that the above eligible change in status event occurred on ____ / ____ / _____

Section B – Employee Information

Social Security Number	Last Name	First	Initial
			()
Street Address	City	State	Zip Code
			Home Phone
			()
Agency			Work Phone

Section C – Deduction Information and Authorization

Deduction Information and Authorization - I authorize the State of Illinois to deduct the amount indicated below from each paycheck for my DCAP account.

The number of deductions for semi-monthly or bi-weekly payrolls is 24.
 The number of deductions for monthly payrolls is 12 (university employees could have less than 12).

\$ _____	X	_____	=	\$ _____
Deduction Amt Per Pay		Number of Deductions		Total Annual DCAP Expenses
				(Minimum = \$240.00; Maximum = \$5,000.00)

Section D - Change in Status Code Chart

01	Adoption of dependent *	13	Employee changes employment status from Part-time <50% to Full-time
02	Marriage	14	Spouse commences employment
03	Divorce, legal separation or annulment *	16	Spouse returns from leave of absence
08	Judgment, decree or court order *	18	Spouse changes employment status from Part-time to Full-time
10	Employee commences employment	21	Change in the cost of care
11	Employee returns to payroll (from being on a leave of absence)	24	Coordination of spouse's annual benefit election period

* Reviewed case-by-case

~ Sign the Reverse Side and Return to your Group Insurance Representative ~

Section E – Certification Statement (Please read carefully before signing)

I understand and certify that:

- I may not change or stop my deposits to this account during the plan year unless I experience a qualifying change in status.
- I will forfeit any unclaimed amount remaining in my account at the end of the run-out period. The run-out period ends September 30th following the last day of the plan year.
- I understand that I cannot submit claims for expenses incurred during periods when my spouse or I are not actively working or actively looking for employment.
- I intend to participate in DCAP for the entire plan year. I do not anticipate terminating state service, retiring or going on an unpaid leave of absence.
- I will refund to CMS any incorrect reimbursements or ineligible payments. If I do not repay the debt, the State may take whatever steps necessary to collect the amount owed.
- If my payroll deductions cease for any reason, I understand my participation in the program will terminate on the last day of the pay period in which a check was issued, or the last day I was actively at work, whichever is sooner.
- I understand that if either my spouse or I earn less than \$5,000.00, my DCAP contribution cannot exceed the lowest income.
- I understand that if my spouse is a full-time student or incapable of self-care, my DCAP contribution cannot exceed \$250.00/month for one dependent or \$416.66/month for two or more dependents.
- I understand that if my spouse and I file separate federal income tax returns, my DCAP contribution cannot exceed \$2,500.00.
- To the best of my knowledge, the information on this form is accurate. I am responsible for any discrepancies that may affect my status with the Internal Revenue Service and I will comply with the IRS requirement to file an IRS Form 2441.

Employee Signature: _____ **Date** ____ / ____ / ____

Please return the signed, completed form to your agency Group Insurance Representative

Section F – Agency Approval (To be completed by Group Insurance Representative)

Effective Date: ____ / ____ / ____ Deduction Start Date: ____ / ____ / ____

If enrollment is for a university employee paid over 9 months, enter the End Date of the last expected deduction:
____ / ____ / ____

Organizational Processing Code: _____ Pay Code: _____

GIR Signature: _____ Date: ____ / ____ / ____

Telephone () _____ - _____

GIR Instructions:

- Use the FSA Inquiry Screen option 1, Deduction What If Screen – Benefits Choice Enrollment; or option 2, Deduction What If Screen – Mid-Year Enrollment, to determine the correct Effective Date and Deduction Start Date. If enrollment is for a university employee **paid over 9 months**, enter the End Date of the last expected deduction.
- Forward the original to the FSA Unit at CMS and retain one copy of the form in the member’s file.