



PA State System of Higher Education | Benefits, Hughes Hall | 2986 North Second Street | Harrisburg, PA 17110-1201 | www.pashe.edu

ENROLLMENT FORM FOR DEPENDENT CARE REIMBURSEMENT ACCOUNT

BEFORE COMPLETING THIS FORM, READ INFORMATION ON REVERSE SIDE. PLEASE PRINT OR TYPE.

NAME (Last, First, MI)			EMPLOYEE ID NUMBER	UNIVERSITY
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Employee	Plan Effective Date	Daytime Telephone	E-Mail Address	
Pay Date of First Deduction	Annual Deduction * \$	Biweekly Deduction (Annual Deduction ÷ No. of Pay Periods) \$		
Name(s) of Dependent(s) Eligible for Dependent Care (Last, First, MI)	Date of Birth	Disabled		Relationship (Child, Spouse, Parent, Other)
		Yes	No	

*\$5,000 maximum January 1 to December 31. This maximum is prorated for a new employee based on date of hire.

Calculate only the amount needed to cover your dependent care expenses for calendar year for which you are enrolling.
According to Federal Regulation, any money remaining in the account after all timely claims have been submitted must be forfeited.

I authorize the Pennsylvania State System of Higher Education to reduce my gross biweekly pay by the biweekly deduction specified above.

I understand that in order to receive reimbursement for my dependent care expenses, care must take place while I am at work and if care is provided in my home, I cannot employ a person that I take as a personal exemption on my income tax or my child (unless he/she will be age 19 by December 31 and is not an exemption on my income tax.)

I certify that I understand the rules governing contributions and reimbursements, as described on the back of the form and that the information provided on this form is true and complete. I understand that reimbursement will be made in accordance with the provisions of the plan.

I agree and understand that any misstatement or falsification of material facts will result in my removal from the Dependent Care Reimbursement Account Program and may further cause an IRS and/or State audit with possible additional tax, interest, and penalties.

Employee Signature	Date	Benefits Counselor Name	Clock Number
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I understand that:

1. I may enroll, disenroll, or change my deductions **only** during the annual open enrollment or within 30 days of a Change in Status as defined in the plan document.
2. A Change in Status **must** be reported within 30 days of the event to qualify for a mid-year enrollment or a change in deductions.
3. My gross biweekly pay will be reduced every pay period by the amount I specify on this Enrollment Form.
4. My dependent care account must be used only for IRS approved dependent care expenses incurred during the calendar year.
5. An adult dependent must have gross income less than \$3,200 per year and must reside with employee for more than half of the year.
6. **Under IRS regulation, any amount remaining in my family care account after all timely claims have been submitted must be forfeited.**
7. As a result of reducing my taxable wages for the calendar year, my future Social Security benefit may be lower.

Examples of Change in Status:

- Birth or Adoption of a Child
- Placement for Adoption
- Gain Custody of Dependent
- Lose Custody of Dependent
- Child Becomes 13 Years Old
- Death of Dependent
- Marriage
- Annulment
- Legal Separation
- Divorce
- Death of Spouse
- Change in Residence of Self, Spouse, or Dependent That Affects Eligibility for Coverage
- Change in Employment Status of Self, Spouse, or Dependent (includes start or end of employment, strike or lockout, beginning or end of a leave without pay, and change in worksite)
- Change in Provider
- Significant Increase in Cost of Dependent care (provider cannot be a relative)
- Decrease in Hours of Dependent Care
- Dependent Receiving Care is No Longer Eligible

Reimbursement claim forms are available on line at www.passhe.edu/benefits or from your University's Human Resource Office.