Clear

COUNTY OF SANTA CRUZ

DEPENDENT CARE REIMBURSEMENT PLAN (D-CARE)

CHANGE IN ENROLLMENT FORM

I hereby certify that I am a County of Santa Cruz employee currently participating in the County of Santa Cruz (County) Dependent Care Reimbursement (D-Care) Plan and request/authorize a change in funding my D-Care account with theCounty:

I have reviewed the provisions of the County of Santa Cruz Dependent Care Reimbursement (D-Care) Program, which authorizes permitted election changes under the Code of Federal Regulations (CFR) Section 1.125-4. Based on my review and current situation, I wish to either (1) cancel the remaining deductions for the remaining period of the current calendar year, or (2) make a change to the amount deducted during the current planyear. Please select an option below.

☐ **Option 1 (Cancel remaining deductions)** ☐ **Option 2 (Change deduction amount)**

Please specify in detail the qualifying event, date of event, and impacted dependents.

I understand that by signing this amendment I am authorizing the adjusted pay period installment, as outlined below. Any funds remaining in my D-Care Plan at the end of the Plan Year will be forfeited and will not be refunded to me.

ORIGINAL CURRENT PLAN YEAR AMOUNT:_____

ADJUSTED PLAN YEAR AMOUNT:_____

ADJUSTED PAY PERIOD INSTALLMENT:_____

EFFECTIVE PAY PERIOD*:_____

*For plan year 2020, the effective pay period will be no sooner than pay period 7.

PLEASE PRINT

Employee Name:_____

Mailing Address:_____

Last Four Digits of SSN:_____ Employee Payroll#:_____ Work Phone:_____

Signature:_____ Date:_____

RETURN THIS COMPLETED FORM TO THE AUDITOR~CONTROLLER'S OFFICE

Use DocuSign, email a scanned copy to AUDPayroll@santacruzcounty.us, or mail to
701 Ocean Street, Room 100, Santa Cruz, CA 95060
831-454-2500