

# HEALTHY DOLLARS

## DCA BENEFIT ENROLLMENT

**Company Name:** \_\_\_\_\_

Employee: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Dependent Info – Please list all eligible dependents & spouse.

Name: (Last, First MI)	Date of Birth	Social Security Number

	Annual Election	Deduction Per Pay Period	Number of Pay Periods
Dependent Care Account (\$5000 Limit)			

I hereby elect to participate in my company's DCA plan agreeing to be bound by all terms, condition and limitations to the Plan. . Any Dependent Care Assistance expenses claimed here were provided for my dependent under the age of 13 or for a dependent that is incapable of self-care. I understand that I must keep copies of all debit card transaction receipts and can be asked to submit them at anytime throughout the plan year. I also agree that if I cannot produce a copy of the requested receipt the transaction will be deemed ineligible and I will have to refund the plan for the total expenses.

Signature of Employee: _____	Date: _____
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**\*\*Waiver of Participation\*\*\***

I have been given the opportunity to enroll in the DCA, but I DO NOT WISH to participate.

Signature of Employee: _____	Date: _____
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