DCA Enrollment / Change Form

☐ ENROLLMENT ☐ CHANGE ☐ TERMINATION EMPLOYER: ______________________________

First Name:		Last Name:	
Social Security Number:		Date of Birth:	
Phone Number	☐ Home ☐ Cell	Email:	
Effective Date:		Address:	

Dependent Information:

Last Name	First Name	SS #:	Date of Birth

Election:

	Annual Election	Deduction Per Pay Period	First Payroll Date
Dependent Care Account			

Authorization I hereby elect to participate in my employer's DCA plan agreeing to be bound by all terms, condition and limitations to the Plan. I understand that I must keep copies of all receipts and can be asked to submit them at any time through 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 be required to refund the plan for the total expenses.

☐ I **ELECT** to participate in the Healthy Dollars Plan ☐ I **DO NOT** elect to participate in the Healthy Dollars Plan

Employee Signature: ____ Date: ______________

*** **For Accurate Enrollment Please Write Clearly** ***

October 2020