Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

DEPENDENT CARE ASSISTANCE PLAN (DCAP) ENROLLMENT/CHANGE FORM

Must print in Black or Blue ink only

Employee ID	Rcd No.	Last Name, First Name	E-mail Address
Mailing Address, City, State, Zip Code			Telephone

REASON FOR ELECTION

☐ **DCAP Open Enrollment**	☐ **New Employee - Date of Hire:**
☐ **Family Status Change - Date of Event:**	
Event Type (ex: Birth/Adoption, Termination, Reduction in Hours, Spouse Gained Employment):	

CONTRIBUTION ELECTION

I elect to have the following amount deducted from my salary and deposited in my DCAP reimbursement account during the Calendar Year (annual deposit cannot exceed $5,000 of your spouse's earned income, whichever is less):

$ _____	x _____	= $ _____
DCAP contribution per pay period	Number of pay periods Calendar year = PP1 through PP 26 (contact EBSD-HR for this information)	Annual DCAP Election

EMPLOYEE AUTHORIZATION

I elect to participate in the County of San Bernardino's Dependent Care Assistance Plan (DCAP). I certify that I have read and agree to the terms and conditions in the DCAP Plan Document. I understand that:

- This election year is in effect for the current Calendar Year (pay period 1 through pay period 26) only. I must re-enroll each Calendar Year in which I wish to participate.
- My taxable salary will be reduced by the amount I have elected to contribute on a before-tax basis.
- This amount will be deposited in my DCAP reimbursement account each pay period.
- I authorize the County to deduct the amount specified above from my pay each pay period, plus an administrative fee of $0.70. Claims for reimbursement must be for eligible expenses incurred from the effective date of my participation in this Plan through the end of the Calendar Year.
- All claims must be filed within 31 days after the end of the Calendar Year. I understand that any claims I submit are for expenses incurred for the care of myself, spouse, or my eligible federal tax dependent(s) as defined by Internal Revenue Code Section 152 and the DCAP Plan Document. Amounts unclaimed by January 31 following the end of the Calendar Year will be forfeited in accordance with Internal Revenue Code Section 129.
- During the Calendar Year, I cannot make any contribution changes, including canceling my contributions, unless I experience an Internal Revenue Code Section 125 qualifying change-in-status event. I will advise my department payroll specialist of change in my family status that affects this election within 60 days of the event.

Employee Signature		Date
Payroll Specialist (Print & Sign)	**Telephone**	**Date**

HR EBSD/EMACS Office Use Only

Benefit Plan ID	Benefit Plan Eff. Date	Keyed by EMACS (Employee ID)	DCAP Fee (DCAPFE)	Date	Audited By (Employee ID)	Date	Enrolled in 1Cloud
			☐				☐

Distribution: Original New Hire - EMACS (0030)
Midyear Change or Open Enrollment - EBSD (0440)