TotalBen Dependent Care Assistance Plan

Enrollment Form

EMPLOYER INFORMATION

Company Name

EMPLOYEE INFORMATION

Employee Last Name	First Name	Social Security Number	
Street Address	**City**	**State**	**Zip**
Daytime Phone Number	**Email**		

DEPENDENT CARE ASSISTANCE PLAN ("DCAP") ELECTION

- I elect to participate in the DCAP as shown below. I agree to reduce my future compensation by the total annual election shown below. This amount will be contributed on my behalf to the DCAP. I understand that this reduces my wages for Social Security purposes.
- I understand that this election must be made annually, in advance of the plan year, and that I may not change this election unless I experience a qualifying event as defined by IRS regulations. Examples of qualifying events include but are not limited to Marriage, Divorce, change in employment status, change in spouse employment status, dependent no longer eligible, birth or adoption of a child. Changes made due to qualified status changes must be made within 31 days of the qualifying event.
- Claims for reimbursement under the DCAP must be for services received and paid during the plan year and must be submitted for reimbursement within three months of the end of the plan year or within three months of termination if my participation in the plan terminates prior to the end of the plan year.
- I understand that any contributions in the DCAP not used for eligible expenses during my participation in the plan and during the plan year will be forfeited to the plan.

DCAP Election – Minimum $100; Maximum $5,000

Total Annual Contribution:

$

Must be a whole dollar amount

Election is for the current Plan Year

Dependent Care Assistance Plan general guidelines:

- Care is for your child or children under age 13,
- A dependent who is unable to care for themselves and regularly spends 8 or more hours per day in your home may also qualify,
- Services are for care of the dependent (not education),
- Care provided by someone who is not your minor child,
- If married you and your spouse must be employed or a full-time student
- Annual amount cannot be more than ½ your income or more than your spouse's income, whichever is lower.

For some employees the Federal Dependent Care Tax Credit may be a better choice. Consult a tax advisor if you have questions.

TERMS AND CONDITIONS

I understand that:

1. Only an IRS-approved qualifying life event (as described in the DCAP Summary Plan Description) allows me to change or suspend my participation in the DCAP.
2. I cannot include any insurance plan premiums in my above projected expenses because these are not reimbursed by the DCAP.
3. I have 90 days after the Plan Year to file claims incurred this Plan Year (no exceptions).Any money in my account after that time will be forfeited.
4. The amount a Highly Compensated Employee may contribute to the DCAP may be limited, subject to results of a nondiscrimination test.
5. All income tax issues should be discussed with my tax advisor.
6. I should retain a copy of this enrollment form for my files.
7. It is my responsibility to see that the correct deduction comes out of my paycheck within 30 days of my participation and to notify my employer immediately if this does not occur.
8. I have read the DCAP Summary Plan Description (SPD) and agree to be bound by its provisions.

I have read and agree to the terms and conditions set forth on this Agreement.

Employee Signature	Date

Send completed form and documentation to TotalBen.

FAX: (718) 535-7071

Mail: TotalBen LLC
P.O. Box 100496
Brooklyn, NY 11210