



Employee Benefit Department

**Enrollment/ Change Form**  
**Health Care Reimbursement Account (HCRA)**  
**Dependent Care Reimbursement Accounts (DCAP)**

First Name	Last Name	Middle Initial	Employee ID
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Plan Year	Location Name and Number	Social Security Number
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- Reason for submitting form:  Enrollment  Termination of DCA Enrollment
- Change in Status (DCAP only)

<b>Description of Change in Status:</b>

Indicate new enrollment amounts or changes to current amount:

- |                          |  |                                  |
|--------------------------|--|----------------------------------|
| <input type="checkbox"/> | <b>Dependent Care Reimbursement Account</b><br>\$5,000 maximum if single or married<br>\$2,500 if married and filing separate income tax return  | <b>Annual Contribution</b><br>\$ |
| <input type="checkbox"/> | <b>Health Care Reimbursement Account</b><br><i>(May be elected during Annual Open Enrollment Only)</i><br>\$5,000 maximum election for Full Time employees<br>\$2,500 maximum election for Part Time employees | \$                               |

Calculation for Per Pay Period Contribution			
Annual Election Amount	Divided (÷) by Number of Pay Periods Remaining (26 Pay Periods in a Plan Year)		Pre-tax Deduction per Paycheck
		=	

I authorize the reduction of my salary on a per paycheck basis, by the amount designated above. I understand that I may not change my election to participate in the Health Care Reimbursement Account. I also understand that I may only make changes to my Dependent Care Assistance Plan account if I have a qualified change in status.

I understand that if I do not incur dependent care expenses equal to my deductions by December 31st any amount remaining in my Dependent Care Assistance Plan account will be forfeited. I understand that if I do not incur health care expenses equal to my deductions by March 15th of the following year, any amount remaining in my Health Care Reimbursement account will be forfeited.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*