COUNTY OF SANTA CRUZ
AMENDED AND RESTATED

D-CARE: DEPENDENT CARE REIMBURSEMENT PROGRAM
2023 PLAN YEAR ENROLLMENT FORM

~ Annual Enrollment Required ~

I hereby elect to participate in the County of Santa Cruz Dependent Care Reimbursement Program (D-Care). I authorize the Plan Year amount of $_____ ($5,000 annual maximum; $2,500 if married filing separately) to be withheld in equal installments of $_____ from each of my 26 bi-weekly paychecks during the Plan Year for the purpose of funding my D-Care account. I understand that this salary deduction will be effective beginning Pay Period One for Calendar Year 2023. If I am hired after Pay Period One of Calendar Year 2023, this salary deduction will be effective the first full pay period of employment with the County and will remain in effect until the last pay period of Calendar Year 2023.

I understand that:

- If I do not complete and return an enrollment form during the Open Enrollment period (9/19/22-10/14/22), I will have forfeited the opportunity to participate in this benefit for the 2023 Plan Year.

- Under the Code of Federal Regulations (CFR) Section 1.125.4 – *Permitted Election Changes:* if a qualifying event exists, the Internal Revenue Service (IRS) allows employees to revoke or make election changes to their plan outside of an Open Enrollment period.

- The Plan Year is January 1 through December 31; however, in accordance with IRS Section 125, the County allows the Plan Year to be extended 2½ months. Therefore, expenses incurred from 1/1/24 through 3/15/24, can also be claimed against 2023 D-Care if a balance exists in the account on 12/31/23. I understand that I must submit claims and receipts for reimbursement of eligible expenses NO LATER THAN 3/31/24. **Funds remaining after 3/15/24 will not be refunded.**

- These dependent care expenses may not be used to claim any Federal income tax deduction or credit (including the dependent care tax credit). I agree to file IRS Form 2441 with my tax return and provide the name, address, social security number or taxpayer identification number for all dependent care providers (persons or organizations) on my Federal income tax return.

- Prior to the beginning of each plan year, I must re-elect participation during open enrollment.

Employee Name (Print): _____

Mailing Address:_____

Employee Payroll #: _____Primary Phone: _____

Employee Signature: _____Date(mm/dd/yyyy): _____

RETURN THIS COMPLETED FORM TO THE AUDITOR-CONTROLLER'S OFFICE
701 Ocean St., Room 100, Santa Cruz, CA 95060
If you have questions, contact the Auditor-Controller's Office at (831) 454-2500