

**COUNTY OF SANTA CRUZ**  
**DEPENDENT CARE REIMBURSEMENT PLAN (D-CARE)**  
**CHANGE IN ENROLLMENT FORM**

I hereby certify that I am a County of Santa Cruz employee currently participating in the County of Santa Cruz (County) Dependent Care Reimbursement (D-Care) Plan and request/authorize a change in funding my D-Care account with the County:

I have reviewed the provisions of the County of Santa Cruz Dependent Care Reimbursement (D-Care) Program, which authorizes permitted election changes under the Code of Federal Regulations (CFR) Section 1.125-4. Based on my review and current situation, I wish to either (1) cancel the remaining deductions for the remaining period of the current calendar year, or (2) make a change to the amount deducted during the current plan year. Please select an option below.

**Option 1 (Cancel remaining deductions)**

**Option 2 (Change deduction amount)**

Please specify in detail the qualifying event, date of event, and impacted dependents.

I understand that by signing this amendment I am authorizing the adjusted pay period installment, as outlined below. Any funds remaining in my D-Care Plan at the end of the Plan Year will be forfeited and will not be refunded to me.

**ORIGINAL CURRENT PLAN YEAR AMOUNT:**\_\_\_\_\_

**ADJUSTED PLAN YEAR AMOUNT:**\_\_\_\_\_

**ADJUSTED PAY PERIOD INSTALLMENT:**\_\_\_\_\_

**EFFECTIVE PAY PERIOD\*:**\_\_\_\_\_

\*For plan year 2020, the effective pay period will be no sooner than pay period 7.

**PLEASE PRINT**

Employee Name:\_\_\_\_\_

Mailing Address:\_\_\_\_\_

Last Four Digits of SSN:\_\_\_\_\_ Employee Payroll#:\_\_\_\_\_ Work Phone:\_\_\_\_\_

Signature:\_\_\_\_\_ Date:\_\_\_\_\_

**RETURN THIS COMPLETED FORM TO THE AUDITOR~CONTROLLER'S OFFICE**

Use DocuSign, email a scanned copy to AUDPayroll@santacruzcounty.us, or mail to  
701 Ocean Street, Room 100, Santa Cruz, CA 95060  
831-454-2500