UNITED ADMINISTRATIVE SERVICES

COUNTY OF SANTA CLARA

DEPENDENT CARE ASSISTANCE PLAN

ELECTION FORM & COMPENSATION REDUCTION AGREEMENT

Employee Information

Employee ID Number	Date of Birth	Social Security Number	
Employee Name	Phone	Email	
Employee Home Address	City	State	Zip
Spouse's Name	Spouse's Employer		

Check One:	☐ Single	☐ Married	☐ Married Filing Separately	☐ Widowed	☐ Legally Separated

Eligible Dependents:	1) Name: DOB:	2) Name: DOB:	3) Name: DOB:	

Pre-Tax Plan Election – I elect to receive the following benefits:

☐ Dependent Care Assistance Plan (DCAP) – election annual maximum: $5,000.00

Per Pay Period Contribution		Number of Pay Periods		Annual Election
$	X		=	$ 0.00

The amount of my compensation reduction for each pay period during the year will be credited to a dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed, up to the balance in that account, for the applicable expenses incurred during the year.

DESIGNATION OF BENEFICIARY

In the event of my death, my beneficiary may have certain obligations and responsibilities under the terms of the Plan. I therefore designate as my beneficiary under the Plan:

Name: _____ Relationship: _____ Address: _____

I elect to receive dependent care assistance for the plan year. I understand the following conditions:

Reimbursement will be available only for qualifying dependent care expenses as described below. I agree to notify my employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse my employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

QUALIFYING DEPENDENT CARE EXPENSES

Under the Plan you will be reimbursed only for the dependent care expenses meeting all the following conditions:

1. The expenses are incurred for services rendered after the date of this election and during the Plan year to which it applies.
2. Each individual for whom you incur the expense is: (a) a dependent under age 13 whom you are entitled to claim as a dependent on your federal income tax return, or (b) a spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself.
3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.
4. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 2(a) above, or who regularly spends at least 8 hours a day in your household.
5. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.
7. The expenses are not paid or payable to an individual for whom you or your spouse is entitled to personal tax exemption as a dependent.
8. The reimbursement (when aggregated with all other reimbursements received by you under the Plan during the same year) may not exceed the least of the following limits: (a) the maximum allowed under the Plan ($5,000; if Married Filing Separately $2,500); (b) your taxable compensation (after all compensation reduction elections); (c) if married, your spouse's actual earned income.

I understand that:

1. I cannot change or revoke this compensation reduction agreement at any time during the plan year unless I have a change in family status (including marriage, divorce, death of a spouse or dependent, birth or adoption of a child, termination of employment of a spouse or unpaid leave of absence).
2. The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
3. The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.
4. The amount of my compensation reduction for each pay period during the year will be credited to a dependent care assistance account and such amount will be paid on my behalf or I will be reimbursed, up to the balance in that account, for the applicable expenses incurred.
5. Any unused dollars allocated to my Dependent Care Reimbursement account shall be forfeited as of the earlier of: (a) the last day of the Plan year, or (b) the date of my termination of employment with my employer.

I understand that I may submit requests for reimbursement within 90 days from the end of the Plan Year or from the date of termination, whichever is earlier. Only expenses incurred during the Plan year or prior to termination, whichever is earlier, are eligible for reimbursement.

I hereby authorize my employer to withhold a service fee of $3.00 per pay period from my compensation for administrative cost of the Plan.

TERMS & CONDITIONS

If you are out on a paid Leave of Absence, you may continue to have deductions taken from your paycheck. Once you are on an unpaid Leave of Absence, deductions will cease. However, in both situations, you may not claim for services while you are on leave.

AUTHORIZATION

My signature below certifies that I authorize my employer to make the appropriate payroll deductions to cover the above elections. My elections cannot be changed during the Plan year, unless I am eligible to make a change. I further understand that this form must be signed and dated prior to my Plan participation to be eligible in the Plan year. Any unused amounts remaining in my account at the end of the Plan year may be forfeited. Any previous election and agreement under the Plan relating to the same benefits, including any prior enrollment form/salary reduction agreement, is hereby revoked. I have read, understand and agree to all of the information indicated on the Plan descriptions.

THIS AGREEMENT IS SUBJECT TO THE TERMS OF MY EMPLOYER'S DEPENDENT CARE ASSISTANCE PLAN AS AMENDED FROM TIME TO TIME, SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH APPLICABLE LAWS, SHALL TAKE EFFECT AS A SEALED INSTRUMENT UNDER APPLICABLE LAWS, AND REVOKES ANY PRIOR ELECTION AND COMPENSATION AGREEMENT RELATING TO SUCH PLAN(S).

Employee's Signature	Date	
Approved by Employer's Authorized Representative	Date	Effective Pay Period