**COUNTY OF SANTA CRUZ**
**AMENDED AND RESTATED**

# D-CARE: DEPENDENT CARE REIMBURSEMENT PROGRAM 2010 ENROLLMENT FORM

~ Annual Enrollment Required ~

I hereby elect to participate in the County of Santa Cruz (County) 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 2010. If I am hired after Pay Period One of Calendar Year 2010, 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 2010.

I understand that:

- Unless there is a change in my family status specifically provided for in the D-Care Plan Document (available on the County Intranet), I cannot change or revoke this benefit election prior to the beginning of the next plan year.

- 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 2 ½ months. Therefore, expenses incurred from 1/1/11 through 3/15/11 can also be claimed against 2010 D-Care if a balance exists in the account on 12/31/10. I understand that I must submit claims and receipts for reimbursement of eligible expenses NO LATER THAN 3/31/11. **Funds remaining after 3/31/11 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.

**PLEASE PRINT:**

Employee Name: _____

Street Address: _____

City: _____ Zip: _____

Employee #: _____ Work Phone #: _____

SIGNATURE: _____ Date: _____

**RETURN THIS COMPLETED FORM TO THE AUDITOR-CONTROLLER'S OFFICE BY 5:00 PM ON THURSDAY, DECEMBER 10, 2009**

**QUESTIONS? CALL THE AUDITOR-CONTROLLER'S OFFICE @ (831) 454-2500**