Special Open Enrollment – Dependent Care Assistance Plan (DCAP) Participants

The government-mandated closure of all schools and 'non-essential' businesses -- and the decision of other employers to implement strict work from home policies in response to the COVID-19 crisis -- has impacted employees who are enrolled in a Flexible Spending Account Dependent Care Assistant Plan (FSA DCAP).

Many who have been impacted by the above are "teleworking," watching the kids, being paid their regular salary and seeing the DCAP payroll deduction taken from their paycheck each pay period.

- Under current IRS regulations, employees who are not working at their normal place of business are generally not eligible for DCAP reimbursement.
- **But there's an exception:** employees being billed by the daycare provider on a consistent basis (let's call this "installment pay") **can** submit claims for reimbursement.

Some participants who are **not** on installment pay arrangements have expressed concerns they will underspend their DCAP monies in the current Plan Year: "In light of the circumstances and the uncertainty regarding my return to my regular workplace, can I make a mid-year change in my DCAP contributions?" The answer is yes! Under IRS regulations, teleworking driven by the COVID-19 crisis is a Qualifying Event, which allows for a "Special Open Enrollment" period – an employee can make a mid-year adjustment but the revised Election Form must be received by the Employer within **30 days** of the employee's Qualifying Event (i.e., the first day that the employee started teleworking).

NOTE:

- **Making a change to your DCAP payroll deduction is optional; your decision should be based on your specific family circumstances.**
- **The payroll deduction change will be prospective – effective on the first payroll date after you submit the revised Election Form to your employer.**
- **Deduction changes only apply for the remainder of the current Plan Year.**
- **You can reduce your future contributions or stop them entirely.**
- **If you are anticipating additional childcare expenses after a return to work, you could increase your contributions; remember, the $5,000 annual family maximum deduction (including a spouse's contribution to his/her DCAP, if applicable) will still apply.**

If you decide to change your deduction, please complete the attached Election Form **– only the shaded areas that are not marked "OFFICE USE ONLY" –** and send the completed form to your employer **before the end of your Special Open Enrollment period** so your payroll deductions can be revised as soon as possible. Your employer will send us a copy of your completed Form and we will update your account information in our DCAP software accordingly.

Please call us at 518.283.8500 if you have any questions.

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FLEXIBLE SPENDING ACCOUNT
EMPLOYEE/EMPLOYER ELECTION FORM/COMPENSATION REDUCTION AGREEMENT

COMPANY/CLIENT NAME		
EMPLOYEE NAME	DATE OF BIRTH / /	DATE OF HIRE / /
SOCIAL SECURITY NUMBER	EMPLOYEE PHONE NUMBER	
ADDRESS: STREET, CITY, STATE, ZIP		
EMPLOYEE EMAIL ADDRESS (REQUIRED)		

ELECTION:

Payroll date _____ (**REQUIRED EMPLOYER - OFFICE USE ONLY**)

ACCOUNT	MIN. ELECTION	MAX. ELECTION	ANNUAL ELECTION (Prorated amount including YTD Contributions)	NUMBER OF PAY PERIODS	DOLLARS WITHHELD/PAY PERIOD
Dependent Care Account (Day Care Expenses for dependents up to Age 13)					

* In the event of a calculation discrepancy, the annual election will be the amount used, and the per pay period amount will be recalculated.

DEPENDENT ENROLLMENT – List ALL dependents that can/will be eligible for reimbursements under Medical and/or Dependent Care accounts.

Dependent Name	Date of Birth (required)	SSN (required)	Relationship

PLEASE REFER TO YOUR SUMMARY PLAN DESCRIPTION REGARDING FORFEITURES, ROLLOVERS, AND GRACE PERIOD EXTENSIONS, AS THEY MAY APPLY TO YOUR PLAN.

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I hereby elect to participate in the Employer's Flexible Spending Account for the Plan Year beginning ____/____/_____ and ending ____/____/_____. Any previous election and compensation reduction agreement relating to the same benefits is hereby revoked and I understand that election is required annually to participate. As a participant, I understand that:

- I cannot change or revoke this agreement during the above Plan Year, unless I have a change in my family status as set forth in the Summary Plan Description.
- My pay will be reduced each pay period by the amount of my election(s) shown on page 1, continuing for each succeeding pay period until this agreement is amended or terminated.
- The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans. If my required contributions change while this agreement is in effect, my payroll reduction will automatically be adjusted to reflect that change.
- My employer may change the amount of my reduction or otherwise modify this agreement, if it believes that the change is required to satisfy provisions of the Internal Revenue Code.
- The amount of my compensation reduction will be credited to the appropriate reimbursement account for payment of eligible expenses incurred within the plan year.
- Reimbursement will be available only for qualifying expenses as described in the attached form. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the Employer, on demand, for any liability it may incur for failure to withhold income or FICA tax from any reimbursement I receive of a non-qualifying expense that I receive.
- Upon request, I will provide the Claims Administrator with the information (e.g., detailed receipts, itemized statements, etc.) needed to substantiate the expenses submitted for reimbursement, if needed by the Claims Administrator to satisfy the relevant IRS regulations, and that my failure to provide the required documentation will result in the deactivation of my debit card and a repayment request.
- If there is a remaining balance in my account(s) at the end of the Plan Year (i.e., after all eligible claims have been reimbursed), I may forfeit that excess amount, based on the provisions of the Plan as detailed in the Summary Plan Description.
- By my signature, I hereby certify that any amounts reimbursed to me under this Plan will not be claimed as a deduction on my personal income tax return and will not be reimbursed to me by other health plan coverage, including a Health Reimbursement Arrangement (HRA) plan or Health Savings Account (HSA) plan

PLEASE NOTE: The pay reductions will not be effective for any pay period that begins before you have signed this form and returned it to your Employer. Please keep a copy of this form for your records.

CHANGES/TERMINATIONS (EMPLOYER – OFFICE USE ONLY)

Date of Event: ____/____/____

First paycheck date that the change will be processed: ____/____/____.

___ Marriage/Divorce
___ Birth/Death of Spouse or Dependent
____ Spouse's employment commenced/terminated
___ Status change from full-time to part-time or part-time to full-time by employee or spouse
___ Unpaid leave of absence by employee or spouse
___ Open Enrollment
___ Employment Termination
___ Another Qualifying Event (describe) _____

Employee Signature_____ Date _____

Employer Signature _____ Date _____

HUMAN RESOURCES – OFFICE USE ONLY (ALL FIELDS REQUIRED)

Highly Compensated ❑ Y ❑ N
Key Employee ❑ Y ❑ N
Officer ❑ Y ❑ N
Spouse or Dependent of Owner ❑ Y ❑ N
More than 5% Owner ❑ Y ❑ N
More than 1% Owner with Salary Greater than $150,000 ❑ Y ❑ N