



The Dependent Care Assistance Program is a division of the Office of Labor Relations' Tax-Favored Benefits Program

DEPENDENT CARE ASSISTANCE PROGRAM (DeCAP) 2009 QUALIFYING EVENT MID-YEAR CHANGE FORM

40 Rector Street, 3rd Floor, New York, NY 10006
Tel: (212) 306-7760 TTY: (212) 306-7629 nyc.gov/olr



Do not write in this box

Agency Payroll Code: _____

1) EMPLOYEE (PARTICIPANT) INFORMATION

Last Name:	First Name:	M.I.:	Social Security Number:	
Home Address - Number and Street:	Apt. No.:	City:	State:	Zip Code:
Agency Name (Not Division):	Home Phone Number (Area Code): ()	Work Phone Number (Area Code): ()		

2) PLEASE INDICATE QUALIFYING EVENT INCURRED AND ATTACH APPROPRIATE DOCUMENTATION

QUALIFYING EVENT*	DOCUMENTATION
<input type="checkbox"/> Marriage	<input type="checkbox"/> Marriage certificate
<input type="checkbox"/> Divorce/legal separation/annulment	<input type="checkbox"/> Divorce decree/separation agreement/annulment decree
<input type="checkbox"/> Death (<input type="checkbox"/> spouse <input type="checkbox"/> dependent)	<input type="checkbox"/> Death certificate
<input type="checkbox"/> Birth of a child	<input type="checkbox"/> Birth certificate or adoption agreement
<input type="checkbox"/> Adoption of a child	<input type="checkbox"/> Adoption agreement and employee's tax return showing eligible dependents
<input type="checkbox"/> Change from F/T to P/T employment or vice versa (<input type="checkbox"/> self <input type="checkbox"/> spouse)	<input type="checkbox"/> Letter from employer
<input type="checkbox"/> Reduction or increase of hours worked (<input type="checkbox"/> self <input type="checkbox"/> spouse)	<input type="checkbox"/> Letter from employer
<input type="checkbox"/> Approved unpaid leave of absence (<input type="checkbox"/> self <input type="checkbox"/> spouse)	<input type="checkbox"/> Letter from employer
<input type="checkbox"/> Beginning or termination of employment (<input type="checkbox"/> self <input type="checkbox"/> spouse)	<input type="checkbox"/> Letter from employer
<input type="checkbox"/> Ineligibility of a dependent	<input type="checkbox"/> Letter from employer or birth certificate

* The Participant has the burden of proof to show that the Qualifying Event is acceptable under the Plan. The Plan Administrator reserves the right to request additional information. The Plan Administrator has, among other duties, the power and duty to interpret the Qualifying Event and to resolve ambiguities, inconsistencies and omissions.

3) PLEASE INDICATE THE CHANGE YOU WISH TO MAKE

The change must be consistent with your Qualifying Event and described on the FSA 2009 Enrollment/Change Form, which you must return with this form within 30 days of the Qualifying Event.

Change existing account: Increase goal amount to: \$ _____ Decrease goal amount to: \$ _____

Start account (*Please complete an FSA 2009 Enrollment/Change Form*)

Terminate account

4) EMPLOYEE (PARTICIPANT) SIGNATURE

This is to certify that on _____, 20____ I incurred the Qualifying Event indicated above and, therefore, wish to modify my benefits as indicated. I understand that the change(s) in benefits requested must be consistent with the Qualifying Event, and that I must provide approved documentation of all change(s), and that the effective date of the change will be the date the forms are received by the Plan Administrator or the date of my first payroll deduction if I become eligible after the beginning of the Plan Year.

Signature: _____ Date: _____

Send the FSA 2009 Enrollment/Change Form with this form and all documentation, within 30 days after the Qualifying Event, to:

Flexible Spending Accounts Program
DeCAP
40 Rector Street, 3rd Floor
New York, NY 10006

OFFICE USE ONLY (Do not write in this box)

Approved date: _____
Effective date: _____
Payroll: _____
Database: _____
Denied by: _____ Sent: ____ / ____ / ____
Pending documentation: _____
Notes: _____