DEPCARE FSA ENROLLMENT, CHANGE, OR CANCELLATION SALARY REDUCTION AGREEMENT—

ACADEMIC STUDENT EMPLOYEES/GRADUATE STUDENT RESEARCHERS ONLY

UPAY 919—ASE/GSR (W10/11) University of California Human Resources

Fill in all the pertinent information. Shaded areas are for accounting use only. Send this form to your Accounting or Benefits Office or to the person handling benefits for your departments.

This form pertains to the Dependent Care Flexible Spending Account (DepCare FSA) program. Use this form to enroll, change your contribution, or cancel your enrollment in either plan during the calendar year.

For additional information regarding coverage effective dates, contact your Benefits Office or the person in your department who handles benefits.

DEPCARE FSA LIFE STATUS CHANGE EVENTS

CODE		ENROLL	INCREASE	DE-ENROLL	DECREASE
	CHANGE IN MARITAL STATUS				
A-1	You marry and gain a dependent	YES	YES	NO	NO
A-2	You marry and your spouse is either not employed, or is enrolled in his or her own employer's dependent care FSA	NO	NO	YES	YES
A-3	You lose your spouse through death, divorce, legal separation or annulment and your spouse was enrolled in his or her own employer's dependent care FSA	YES	YES	NO	NO
	GAIN OR LOSS OF A DEPENDENT				
B-1	You gain an eligible dependent (for example, through birth, adoption, or your spouse becomes incapable of self-care)	YES	YES	NO	NO
B-2	You lose an eligible dependent (for example, through death, a child reaches age 13, or a child is no longer a tax dependent)	NO	NO	YES	YES
	CHANGE IN EMPLOYMENT STATUS				
C-1	Your spouse gains eligibility for and enrolls in own employer's dependent care FSA because he/she starts employment, or has an employment status change	NO	NO	YES	YES
C-2	Your spouse loses eligibility in own employer's dependent care FSA because he/she ends employment, or has an employment status change Note that in order for a married employee to be or remain eligible for DepCare, the spouse must either be employed or be looking for employment (or, if not, must be a full-time student or incapable of self-care).	YES	YES	NO	NO
	COST CHANGE (DOES NOT APPLY IF PROVIDER IS YOUR RELATIVE BY BLOOD OR MARRIAGE)				
D-1	Your dependent care provider increases the cost of services	YES	YES	YES	YES
D-2	There is a decrease in provider's cost	YES	NO	NO	YES
	CHANGE IN PROVIDER OR COVERAGE				
E-1	You change dependent care providers	YES	YES	YES	YES
E-2	There is a reduction in hours or cessation of dependent care (for example, a child starts attending school)	NO	NO	YES	YES
E-3A	You change (in whole or in part) from paid care to no care or free care (for example, free care by a neighbor or relative or for state-paid care)	NO	NO	YES	YES
E-3B	you change (in whole or in part) from free or no care to paid care	YES	YES	NO	NO
E-4	Your spouse starts employment	YES	YES	NO	NO
E-5	Your spouse ends employment	NO	NO	YES	YES
E-6	You or your spouse changes work schedule (for example, going from full-time to part-time or vice versa) which creates, changes or eliminates need for dependent care.	YES	YES	YES	YES
E-7	Your spouse who is not employed or looking for employment becomes a full-time student, or becomes incapable of self-care	YES	NO	NO	NO
E-8	Your spouse who is not employed or looking for employment is no longer a full-time student or is no longer capable of self-care	NO	NO	YES	NO

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1. PERSONAL INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)	EMPLOYEE ID NUMBER
CAMPUS/LAB	**CAMPUS/LAB PHONE**
	( )

2. EMPLOYEE ACTION—Type of Event/Contribution Election

The effective date for enrollment or change actions is the first of the month following your change or enrollment, subject to payroll deadlines. Your monthly contribution will appear on your earnings statement.

☐ **Open Enrollment**—Effective date for Open Enrollment actions: January 1 of the following year.

Enter your contribution amount: DepCare FSA $_____/year

Your monthly contribution will be calculated by dividing the annual amount you elect by twelve monthly contributions.

☐ **Period of Initial Eligibility Enrollment (PIE)**—when you enroll in the plan this calendar year because:

- you are newly hired or rehired, or
- you are hired into an appointment making you eligible for the plan(s)
- reenroll when you return from an unpaid leave of absence

Enter your contribution amount: DepCare FSA $_____/year

Your monthly contribution will be calculated by dividing the annual amount by the number of monthly contributions remaining in the year.

☐ **Life Status Change**—Changes permissible due to these events must be on account of and correspond with the event. Check the reason you are completing the form, enter the code for the event that applies to you (refer to chart on cover page), and enter the date of the event and your contribution amount.

Type of Action ☐ Enroll ☐ Change Contribution (increase or decrease) ☐ De-enroll

DepCare FSA: Code (for example B-2):_____ DATE OF EVENT MO / DAY / YEAR DepCare FSA $_____/year

Your monthly contribution will be calculated by dividing the annual amount by the number of monthly contributions remaining in the year.

3. SIGNATURE

My signature below indicates I have read and agree to the "Terms and Conditions" on this form. I certify under penalty of perjury that all of the above information is true to the best of my knowledge and, if applicable, that I have experienced the event and/or cost change noted above.

EMPLOYEE'S SIGNATURE	DATE

FOR OFFICE USE ONLY

SYSTEM UPDATED BY	DATE	COVERAGE EFFECTIVE DATE MO DY YR

RETN: OFFICE: 5 YEARS FOLLOWING SEPARATION, EXCEPT IN CASES INVOLVING DISABILITY RETIREMENT OR DISCIPLINARY ACTION, RETAIN UNTIL AGE 70.

SEE PAGE 3 FOR PRIVACY NOTIFICATIONS

PRIVACY NOTIFICATIONS

STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting information on this form, including your Social Security number, is to verify your identity, and/or for benefits administration, and/or for federal and state income tax reporting. University policy and state and federal statutes authorize the maintenance of this information.

Furnishing all information requested on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be transmitted to the federal and state governments when required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from campus or Office of the President Staff and Academic Personnel Offices.

The official responsible for maintaining the information contained on this form is the Associate Vice President—University of California Human Resources, 1111 Franklin Street, Oakland, CA 94607-5200.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. The University's record keeping system was established prior to January 1, 1975 under the authority of The Regents of the University of California under Article 1X, Section 9 of the California Constitution. The principal uses of your Social Security number shall be for state tax and federal income tax (under Internal Revenue Code sections 6011.6051 and 6059) reporting, and/or for benefits administration, and/or to verify your identity.

TERMS AND CONDITIONS

By signing this form, you agree to the following terms and conditions:

1. **You understand and accept all terms and conditions for the UC-sponsored plans in which you are enrolled as stated in the plan booklets and UC's Group Insurance Regulations.**
2. **When you specifically ask UC representatives to intercede on your behalf with your plan administrator, you authorize the administrator to release to the UC representatives the pertinent records pertaining to you and/or your family member(s).**
3. **You authorize deductions from your earnings to cover your monthly contributions.**
4. **Actions you take during Open Enrollment will be effective the following January 1. Continued participation in DepCare FSA requires annual enrollment during Open Enrollment.**