## **Dependent Care Change of Status Form** (Please complete this form and return it to your Human Resource Department)



<b>1</b> Personal Information			
Employee Name	Co	ompany Name	
Street Address, City, State, Zip			Current Date
Date of Event Social Secur	ity Number		
2 Qualifying Event			
☐ Change Cost or Provider – Dependent C	Care i.e. Change of Di	ay Care Provider, Cost Increas	es or Decreases
<b>3</b> Change of Benefit			
The payday that the new deduction beg	gins:		
Date of last payroll deduction:			
	Prior Annual Election Amount	New Annual Election Amount	Frequency of Withholding (weekly, semi-monthly, etc.)
Day Care Expense			
☐ Please discontinue my dependent care deductions			
4 Employee Signature/Company	Representative Signa	iture	
Employee Signature			Date