Dependent Care Change of Status Form

(Please complete this form and return it to your Human Resource Department)

1 Personal Information

Employee Name _____ Company Name _____

Street Address, City, State, Zip _____ Current Date _____

Date of Event _____ Social Security Number _____

2 Qualifying Event

☐ Change Cost or Provider – Dependent Care i.e. Change of Day Care Provider, Cost Increases or Decreases

3 Change of Benefit

The payday that the new deduction begins: _____

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 Signature

Employee Signature _____ Date _____

Company Representative Signature _____ Date _____

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