

City of Modesto

Dependent Care Assistance Program (DCAP)

EMPLOYEE ENROLLMENT AND SALARY REDUCTION AGREEMENT

APPLICANT	Employee Name (Last, First, Middle)		Group Name City of Modesto		Effective Date Jan 1, 2011–Dec 31, 2011		
	Employee Home Address (Reimbursement Checks are sent to this address)			City		State	ZIP
	Employee Social Security Number - -		Date of Birth / /		<input type="checkbox"/> Male <input type="checkbox"/> Female		Married <input type="checkbox"/> Yes <input type="checkbox"/> No
	Job Title/Occupation		Date of Hire / /		Earnings \$ <input type="checkbox"/> Monthly <input type="checkbox"/> Annual		Phone # Hours Worked

AUTHORIZATION FOR COVERAGE AND PARTICIPATION

I request the following amounts to be deducted from my salary **per pay period (bi-weekly)**, as follows:

Total Amt _____	Deduction for Dependent Care Expenses	\$ _____	(take total amt divide by 26 pay periods)
	Administration fee is	\$ <u>1.62</u>	
	Total	\$ _____	

I understand all qualified expenses must be incurred prior to the plan year end.
Unused amounts will be forfeited. () Initial

OPTIONAL DIRECT DEPOSIT ELECTION AUTHORIZATION

I elect and direct Administrative Solutions, Inc. to initiate deposits and/or corrections to the financial institution listed below.

Direct Deposit Reimbursements are electronically deposited into your bank account. A copy of our voided check must be attached. Deposit slips are not accepted.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">_____ Begin Deposits</td> <td style="width: 50%;">_____ Check</td> </tr> <tr> <td>_____ Cancel Deposits</td> <td>_____ Savings</td> </tr> </table>	_____ Begin Deposits	_____ Check	_____ Cancel Deposits	_____ Savings	Routing #: _____ Account #: _____ Bank Name: _____
_____ Begin Deposits	_____ Check					
_____ Cancel Deposits	_____ Savings					

I understand electronic funds transfer (EFT) will be initiated on the normal check run date. Deposits may take up to three (3) business days to appear in the designated account. Returned items due to incorrect banking information will be assessed a \$25.00 fee.

I certify the information above to be correct and true to the best of my knowledge. I authorize payroll deductions from my earnings for any contribution I am making toward the cost of any of the above. Applicable account(s) at the end of the plan year not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Section 125 Flexible Benefit Plan deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status as defined in the Plan Document.

Signature

Date

Administrative Solutions, Inc.
 555 W. Shaw Ave., Suite C-1
 Fresno, CA 93704
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 (866)777-1320 / FAX (866) 333-1321