# Dependent Care FSA Enrollment Changes due to Dependent Care Changes- COVID-19

## **Question:** Does the COVID-19 emergency qualify as a reason for an employee to be able to make mid-year election changes to their dependent care FSA (**also called a dependent care assistance plan or DCAP**)?

The answer depends on which type of plan the employee wishes to change, and what type of change they wish to make, but the rules are the same now as they were before the current pandemic.

Mid-year election changes for FSAs are generally governed by 26 C.F.R. 1.125-4. These rules allow plans to warrant certain types of mid-year changes. Employees making an election change under any of the circumstances below must make a change that is consistent with the reason for making the change.

## The following would likely apply in the case of childcare changes during the COVID-19 emergency:

- If an employee has school-age children and funds their 3 p.m. to 6 p.m. after care using a DCAP. The children's school closes and the employee now needs to pay for child care from 9 a.m. to 6 p.m. The employee would be allowed under IRS rules to increase their DCAP election (up to the maximum of $5,000).
- If an employee has children in a daycare and the daycare closes due to the COVID-19 emergency, this could be considered a qualifying event under IRS rules to decrease or cease your DCAP election. Please note, if you cease your election, you will be unable to re-enroll in the plan until the next open enrollment period for the 2021 plan year.
- If an employee and their co-parent are now working from home due to a COVID-19 stay-at-home order. They no longer need the day care they were using the DCAP to fund. That employee can reduce or cease their DCAP deductions, mid-year. Please note, if you cease your election, you will be unable to re-enroll in the plan until the next open enrollment period for the 2021 plan year.

## To Submit a Mid-Year Change request:

If you wish to request a change to your Dependent Care FSA election (DCAP), please complete the following Enrollment & Change Form Sections highlighted in yellow, sign and date page 3 and complete the entire page 4, following the instructions on page 5. Please return the completed paperwork to Benefits.ServiceRep@ventura.org. On page 3, please include a description of the change (Exp. Daycare closure, etc.), the effective date of the change, and any other pertinent details of the change experienced in highlighted sections noted. You must submit a mid-year change request within 31 days, including the date you experienced the change.

# Flexible Benefits Program Enrollment & Change Form Plan Year 2020

**Instructions: After completion, please return this form, along with any required back-up documentation, to your agency/department's Benefits Representative.**


**County of Ventura Human Resources/Benefits**
**800 S. Victoria Ave., #1970, Ventura, CA 93009-1970**
**(805) 654-2570 · FAX (805) 654-2665**
**Email: Benefits.ServiceRep@ventura.org**
**Intranet: http://myvcweb/index.php/benefits**
**Internet: www.ventura.org/benefits**


**Type of Enrollment**

- ☐ New Enrollment
- ☒ Mid-Year Change Request *(must also complete page 3 of this form)*
- ☐ Add Dependent/Date & Reason_____
- ☐ Cancel Dependent/Date & Reason_____
- ☐ Other_____

## 1. Employee Data (please print)

| NAME (LAST, FIRST, M.I.) | EMPLOYEE ID NUMBER | SOCIAL SECURITY NUMBER | DATE OF BIRTH |
|---|---|---|---|
| ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE |
| HOME PHONE | WORK PHONE | GENDER (M/F) | HIRE DATE |
| AGENCY/DEPARTMENT NAME | BARGAINING UNIT | EMAIL ADDRESS | |

## 2. Medical Plan Coverage (pre-tax rates; see Plan Rates & Flexible Credits-PY 2020 for Flexible Credit Allowance by Bargaining Unit)

- ☐ Ventura County Health Care Plan HMO (EE only = $393.28/biweek, EE+1 = $529.44/biweek, EE + 2 or more = $642.92/biweek)
- ☐ Blue Shield Access+ HMO (EE only = $473.39/biweek, EE+1 = $630.64/biweek, EE + 2 or more = $758.57/biweek)
- ☐ Blue Shield Trio HMO (EE only = $411.93/biweek, EE+1 = $549.18/biweek, EE + 2 or more = $661.22/biweek
- ☐ Blue Shield High-Deductible PPO (EE only = $336.56/biweek, EE+1 = $450.07/biweek, EE + 2 or more = $545.25/biweek)
- ☐ Medical Plan Opt Out - must submit Opt Out Certification Form with proof of eligibility ($300.09/biweek)

## 3. Dental Plan Coverage (pre-tax tiered rates)

- ☐ MetLife Dental PPO (EE only = $21.07/biweek, EE + 1 = $40.16/biweek, EE + 2 or more = $60.73/biweek)

## 4. Vision Plan Coverage (pre-tax)

- ☐ MES Vision (EE only = $2.03/biweek, EE+1 = $3.66/biweek, EE + 2 or more = $5.24/biweek)

## 5. Flexible Spending Accounts (FSA pre-tax; annual re-election is required)

**Health Care FSA (not available if enrolling in the High Deductible PPO):**

- ☐ I elect a Health Care Flexible Spending Account with a semi-monthly pledge of $_____ ($10.00 - $112.50/semi-monthly).

**Dependent Care FSA:**

- ☒ I elect a Dependent Care Flexible Spending Account with a semi-monthly pledge of $_____ ($10.00 - $208.33/semi-monthly).

**Limited-Purpose FSA (only available if enrolling in the Health Savings Account):**

- ☐ I elect a Limited-Purpose Health Care Flexible Spending Account with a semi-monthly pledge of $_____ ($10.00 - $112.50/semi-monthly).

## 6. Health Savings Account (pre-tax; only available if enrolling in the High Deductible PPO)

- ☐ I elect a Health Savings Account with a semi-monthly pledge of $ _____

Individual Coverage – Maximum Biweekly Pledge is $147.91 semi-monthly ($189.58 if age 55 or older)

Family Coverage – Maximum Biweekly Pledge is $295.83 semi-monthly ($337.50 if age 55 or older)

**7. Employee/Dependent Information** (If enrolling in an HMO medical plan, please be sure to designate a primary care physician for yourself and your dependents. You may add additional dependents on a separate sheet of paper. Also, you must attach documentation that supports the relationship for each dependent; required documentation is listed on the following page.)

| NAME (LAST, FIRST, M.I.) | RELATION-SHIP | DATE OF BIRTH | GENDER (M/F) | SOCIAL SECURITY NUMBER | MEDICAL | DENTAL | VISION | PHYSICAN NAME (HMO only) | Previously seen? |
|---|---|---|---|---|---|---|---|---|---|
| **Employee** | **Self** | **See Page 1** | | | ☐ | ☐ | ☐ | | ☐ |
| | | | | | ☐ | ☐ | ☐ | | ☐ |
| | | | | | ☐ | ☐ | ☐ | | ☐ |
| | | | | | ☐ | ☐ | ☐ | | ☐ |
| | | | | | ☐ | ☐ | ☐ | | ☐ |

**8. Signature**

I certify the information on this form is complete and correct, and that all dependents listed meet the eligibility rules of the plan(s) in which I have enrolled them. I authorize County of Ventura HR/Benefits to perform any investigation necessary to verify eligibility for myself and/or my dependent(s). I understand that misstatements, material misrepresentations, or omissions may result in my coverage being void as of its effective date with no benefits payable. I also understand and agree that:

- I received a copy of the Flexible Benefits Program Benefit Plans Handbook, and I have read descriptions of benefits plans in which I am enrolling.
- My coverage elections on this form cannot be revoked or modified until the next open enrollment period, unless I have a qualifying change in status as defined by the IRS (see Benefit Plans Handbook, Chapter 1).
- I will verify that the enrollments and deductions I have authorized on this form have been implemented by reviewing my paystub for accuracy during the first pay period my selections are effective. I agree that failure to report an error within 30 days of the error's first appearance on my biweekly paystub is an affirmative election of the benefits listed on the paystub.
- I will notify the County immediately if I and/or my dependents become ineligible. In the event ineligibility is determined, I understand and agree that coverage will be terminated retroactive to the date I/we became ineligible. I authorize the Auditor-Controller to adjust the amount of payroll deductions/reductions/credits (including retroactive adjustments) necessary to correct any premium over-payments or under-payments.
- My pre-tax pay will be reduced by the amount of any required contributions noted for the coverage(s) elected after my flexible credits have been applied (flexible credit amounts are listed on page 3 of this form). My unspent flexible credits will be taxed and added to my paycheck as "Cash Back."
- My enrolled dependents and I are bound by all the terms and conditions of the plans in which I am enrolling.
- The plan administrator and health care professionals/facilities/representatives are authorized to obtain and/or release medical information from/to appropriate providers/agencies if needed to provide necessary health care services and/or administrative services and/or claim adjudication for myself and my enrolled dependent(s).
- A photocopy of this form is as valid as the original.
- If a disagreement arises regarding coverage under a plan, the dispute or claim shall be submitted to the grievance and/or binding arbitration process as specified by the plan, and not by lawsuit or resort to court process, except as provided by California law.

**Signature** **Date**

**WAIVER OF PARTICIPATION IN THE FLEXIBLE BENEFITS PROGRAM** ***(NOT THE SAME AS OPTING OUT OF MEDICAL COVERAGE; DO NOT SIGN IF YOU WISH TO OPT OUT)***

If you are eligible to participate in the Flexible Benefits Program but DO NOT WANT TO ENROLL, read this WAIVER OF BENEFITS and sign and date where indicated:

WAIVER OF BENEFITS: I have been informed about the County's Flexible Benefits Program. I understand that, if eligible, I am entitled to a Flexible Credit Allowance each pay period if I am enrolled in the Ventura County Flexible Benefits Program. I choose not to enroll and thereby waive and forfeit the County Flexible Credit Allowance. I understand that this decision is binding and that I will not have another opportunity to enroll until the next annual Flexible Benefits Program open enrollment period.

Signature ***(DO NOT SIGN HERE IF YOU ARE ELECTING A PLAN OR OPTING OUT OF MEDICAL COVERAGE. THIS IS FOR WAIVERS ONLY.)*** Date

| **FOR OFFICE USE ONLY** | | | |
|---|---|---|---|
| Department Authorization (Sign & Date) | HR/Benefits Authorization (Sign & Date) | Effective Date | Medical Plan Group ID # |
| | | | |

☐ LTD Cert. Sent ☐ Life Ins. Cert. Sent ☐ COBRA Rights Sent (new spouse)

PY 2020 – revised 10/14/19

# Flexible Benefits Program Mid-Plan Year Change Request Form

**TO BE COMPLETED FOR MID-YEAR CHANGES ONLY**
**(not applicable for new employees' initial enrollment)**


**County of Ventura Human Resources/Benefits**
**800 S. Victoria Ave., #1970, Ventura, CA 93009-1970**
**(805) 654-2570 · FAX (805) 654-2665**
**Email: Benefits.ServiceRep@ventura.org**
**Intranet: http://myvcweb/index.php/benefits**
**Internet: www.ventura.org/benefits**


**The Qualified Event Deadline will not be any later than (31) calendar days from the Qualified Event Date:**

**Qualified Event Date:** _____

**Qualified Event Deadline:** within 31 days of event date

## 1. Employee Data (please print)

_____

**NAME (LAST, FIRST, M.I.)** **EMPLOYEE ID NUMBER**

## 2. Qualifying Mid-Year Event: _____

_____

## 3. Requested Plan Election Changes (please check all that apply)

| Current Plan Year Elections | Requested Mid-Plan Year Elections |
|---|---|
| **Medical Plan Coverage**: | **Medical Plan Coverage**: |
| **Dental Plan Coverage:** | **Dental Plan Coverage:** |
| **Vision Plan Coverage**: | **Vision Plan Coverage**: |
| **Health Care Flexible Spending Account**: | **Health Care Flexible Spending Account**: |
| **Dependent Care Flexible Spending Account**: | **Dependent Care Flexible Spending Account**: |
| **Limited-Purpose Flexible Spending Account:** | **Limited-Purpose Flexible Spending Account:** |
| **Health Savings Account:** | **Health Savings Account:** |

## 4. Employee Signature

The IRS has very specific rules governing when you may change your benefit elections and the required documentation that you should submit when cancelling or adding coverage. The change in your plan selections must be because of and consistent with the reason for the change and with the consequence that there is a gain or loss of coverage due to the change. Employees have 31 days from the date of the qualifying event to enroll, cancel or make changes to their benefit elections. In order to process a change, complete this form, attach the Enrollment and Change form and provide supporting documentation within 31 days of the qualifying event. I understand if I miss the deadline, I must wait until open enrollment to make changes to my benefits.

I certify the information on this form is complete and correct, and that all dependents listed meet the eligibility rules of the plan(s) in which I have enrolled them. I authorize County of Ventura HR/Benefits to perform any investigation necessary to verify eligibility for myself and/or my dependent(s). I understand that misstatements, material misrepresentations, or omissions may result in my coverage being void as of its effective date with no benefits payable.

_____

**Signature** **Date**

| FOR OFFICE USE ONLY | | | |
|---|---|---|---|
| Department Authorization (Sign & Date) | HR/Benefits Authorization (Sign & Date) | Effective Date | Medical Plan Group ID # |
| | | | |

PY 2020 – revised 10/14/19

CHARDSNYDER™ Benefit Solutions

# Participant Change of Status Request Form

| **Company Information** (PLEASE PRINT) | |
|---|---|
| Company Name | Division (If applicable) |

| **Participant Information** (PLEASE PRINT) | | | |
|---|---|---|---|
| Last Name | | Primary Phone | |
| First Name | | Secondary Phone | |
| SSN / (or Alternate Employee ID) | Date of Birth (mm/dd/yyyy) | Email Address (For Account Notifications) | |
| Street Address (Check if New Address ☐ ) | | | |
| City | | State | Zip |

*If your qualifying event was incurred by a spouse or eligible dependent, please provide the following information:*

| **Name** | **Relationship to Participant** | **Date of Birth** |
|---|---|---|
| | | |

## Change of Status — No Changes ☐

*Please check the box next to your Change of Status*

- ☐ Change in Marital Status ( marriage, divorce, death of a spouse, legal separation or annulment)
- ☐ Change in Number of Dependents (birth, adoption, or death)
- ☐ Change in Employment and/or Eligibility of Self, Spouse or Dependent
- ☐ Change in Daycare Provider and/ or Rates (Dependent Care Reimbursement Account Only)
- ☐ Leave of absence in accordance with the Family Medical Leave Act:
  Check one: ☐ Pre-Pay Option ☐ Catch-Up Option ☐ Opt-Out Option ☐ Pay As You Go
- ☐ Other Change

Explanation: _____

_____

## Change of Election

**Healthcare –Flexible Spending Account (FSA)**
Out-of-pocket medical, dental and vision expenses

**Payroll Deduction Amount X (Number of Pays) = Annual Election**

**$**_____ **X** _____ **= $**_____

**Dependent Daycare –Flexible Spending Account (FSA)**
Child and/or adult daycare expenses

**Payroll Deduction Amount X (Number of Pays) = Annual Election**

**$**_____ (within 31 days of event date) **X** _____ **= $**_____

## Certification

I hereby certify that the information supplied on this form is true and accurate. **I understand that if I submit a false or deceptive statement, I am guilty of insurance fraud under state and/or federal law.**

Employee Signature _____

Date _____

*(For HR office use only)*

☐ Approved ☐ Denied

Effective Date : _____

HR Representative Initials: _____

# Participant Change of Status Request Form Instructions

1. **Complete all company and employee information** on the front page (please print/type)
2. **Check the box** next to the change of status you have experienced
3. **Provide an explanation** of the event if you checked *Other*
4. **Fill in the spaces** for the deduction(s) you wish taken from your pay each pay period, the number of pay periods left in the year and the total amount for the year
5. **Return this form** to your Human Resource Representative on or before the end of your change of status grace period