

Administrative Office of Pennsylvania Courts



DEPENDENT CARE ACCOUNT

2023 OPEN ENROLLMENT FORM

Before completing this form, please carefully read the information on the reverse side. Please print or type. Unless you become eligible for mid-year enrollment because of a qualified change of status, this form must be received by the AOPC Payroll Unit **on or before December 16, 2022** to enable you to participate in the Dependent Care Account Program during 2023. You should carefully estimate your qualified dependent care expense for the calendar year (see statements 1 – 5 on page 2).

| | |
|--|------------------------------------|
| Employee Name | |
| _____ | XXX - XX - _____ |
| Last name, first name & middle initial | Last 4 digits of social security # |

| | |
|--|---|
| Amount to be deducted per pay period | Total amount to be deducted for 2023 |
| \$ _____ | \$ _____ |
| Not less than \$25 per biweekly pay period or \$50 per monthly pay period. | |

| Name(s) of Eligible Dependent(s) <small>(Last, First, Middle Initial)</small> | DATE OF BIRTH | | | DISABLED | | RELATIONSHIP | | |
|--|---------------|-----|------|----------|----|--------------|--------|--------|
| | Mo | Day | Year | Yes | No | Child | Spouse | Parent |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Employee Signature

Date

Please return completed form to:
 Payroll Unit
 The Administrative Office of Pennsylvania Courts
 P.O. Box 61260
 Harrisburg, Pennsylvania 17106-1260
 EMAIL: Payroll@pacourts.us

Dependent Care Account Enrollment Form

I have received and read the Employee Information Booklet regarding the Dependent Care Account Program and understand the regulations governing contributions to and reimbursements from my Dependent Care Account. I understand that:

1. I may enroll, terminate participation or change my deduction during the remainder of 2023 **only** if I have a Qualified Change of Status listed below.
2. Any change to my Dependent Care Account deduction must be made within 60 calendar days of the Qualified Change of Status.
3. My gross salary will be reduced by the deduction amount I specify per pay period until the amount deducted equals the total annual amount I specify.
4. The deduction from my gross salary will begin with the first regular payroll of the calendar year following the receipt of my enrollment form by the Payroll Department.
5. The total annual amount to be deducted which I specify must not be greater than the amount allowable by IRS for my tax filing status and other criteria. If my annual deduction is greater than the amount allowable, I may have to pay the applicable taxes on the excess.
6. IRS regulations require that any money remaining in my account after all qualified reimbursements for the calendar year and the grace period ending March 1, 2024 have been paid cannot be returned to me or carried forward to the next year but **must be forfeited**. I have until March 1 to submit a claim for eligible expenses for the prior year and the grace period.
7. I am responsible for maintaining the required documentation to substantiate my eligibility for the program and my dependent care expenses.
8. By participating in the Dependent Care Account Program, my social security wages and tax will be reduced and consequently my future social security benefits may be lower.

Qualified Change of Status Events

- | | |
|----|---|
| 01 | Birth or adoption of a child |
| 02 | Placement for adoption |
| 03 | Gain custody of dependent |
| 04 | Lose custody of dependent |
| 05 | Child becomes 13 years old |
| 06 | Death of dependent |
| 07 | Marriage |
| 08 | Annulment |
| 09 | Legal separation |
| 10 | Divorce |
| 11 | Death of a spouse |
| 12 | Change in residence of self, spouse or dependent that affects eligibility for coverage |
| 13 | Change in employment status of self, spouse or dependent including the start or end of employment and the beginning or end of leave without pay |
| 14 | Change in provider |
| 15 | Significant increase or decrease in cost of dependent care if the provider is not a relative |
| 16 | Increase or decrease in hours of dependent care |
| 17 | Dependent receiving care is no longer eligible |

If you have any questions regarding the Dependent Care Account Program, please feel free to call the AOPC Payroll Unit at 717-231-3325.