

**GROUP BENEFIT ADMINISTRATORS  
OF CONNECTICUT (GBAC)  
ENROLLMENT/CHANGE FORM  
PLEASE PRINT CLEARLY (Do not abbreviate)**



**EMPLOYER NAME: State of Connecticut**

Last Name	First Name	MI	Social Security Number	
Home Address	City	State	Zip	
Daytime Phone ( ) ( )	Home Phone ( ) ( )	Date of Hire	Date of Birth	E-mail Address:

<p>Enrollment Status:</p> <p><input type="checkbox"/> New Hire or <input type="checkbox"/> Open Enrollment</p> <p>Record Number - (Contact your Agency): _____</p> <p>Employee ID - (On Paycheck Stub): _____</p> <p>Primary Department ID - (On Paycheck Stub) _____</p> <p><b>*Please note, your application will not be processed unless your Record Number, Employee ID, and Primary Department ID are entered into the application.*</b></p>	<p>If status change, indicate reason:</p> <p><input type="checkbox"/> Change in Status - Date of Event: _____</p> <p><u>Dependent Care Spending Account</u></p> <p><input type="checkbox"/> Your need for dependent care changes</p> <p><input type="checkbox"/> Your dependent care provider changes</p> <p><input type="checkbox"/> The costs of dependent care increases by more than 10% (and care is not provided by a relative)</p> <p>You may be permitted to change your DCA election if you have a qualifying status change. To make a change, you must report the change within <b>31 days</b> of the event to Progressive Benefit Solutions. All changes are subject to Plan Administrator approval.</p> <p>Only expenses incurred on or after the date of your qualifying status change are eligible for reimbursement under the new election.</p>
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<b>Dependent Care Spending Account (DCAP)</b>	<b>Qualified Transportation (TFBP)</b>
<p>Used for eligible dependent care expenses incurred so that you and your spouse (if married) can work. Maximum contribution: \$5,000 (\$2,500 if married filing separately)</p> <p>Annual Election Amount \$ _____</p> <p>Per payroll Amount \$ _____</p> <p><input type="checkbox"/> Waive Coverage</p>	<p>Used for eligible qualified transportation expenses for mass transit and/ or parking: Mass Transit Maximum Monthly = \$115 Parking Maximum Monthly = \$220</p> <p>Monthly Election Amount: Parking Pre-Tax \$ _____</p> <p>Mass Transit Pre-Tax \$ _____</p> <p><input type="checkbox"/> Waive Coverage</p>

Pay Frequency:  Bi-weekly  Semi-monthly  Monthly

Acknowledge that:

- I authorize my employer to reduce my pay on a pre-tax basis by the total amount of the contribution(s) noted-above.
- I understand that I **cannot change or revoke** my election(s) prior to the end of the Plan Year for which it is in effect unless I experience a Qualifying Status Change as permitted by the Plan and Section 125 of the Internal Revenue Code. Any changes to my election(s) must be filed with and approved by **Group Benefit Administrators of Connecticut (GBAC)** within **31 days** of the status change date.
- Any pre-tax elections I have made here will reduce my compensation for Social Security tax purposes, which could reduce my social security benefits slightly.
- Any amounts remaining in my Dependent Care spending account (DCAP) after the end of the plan year, will be **forfeited** as required by IRS law.
- I understand that my contributions can only be used for the payment of expenses incurred during the plan year for which this agreement is in affect.
- I understand that I can change my election(s) prior to the end of the plan year for QTA (Qualified Transportation). QTA plans are governed by Section 132 of the Internal Revenue Code. Any changes must be reported to **Group Benefit Administrators of Connecticut (GBAC)** within **31 days** of the status change.
- All claims submitted for reimbursement are subject to substantiation requirements and I will be required to **retain all itemized receipts/statements and offer them as proof of eligibility** when requested by the Plan Administrator, Claims Administrator (Group Benefit Administrators of Connecticut (GBAC) or the IRS.
- I agree to use the benefits debit card for eligible expenses only.
- I understand the benefits debit card will be inactivated if I do not comply with the provisions of the Plan/card or upon termination of employment.
- I am responsible for any fees associated with the benefits debit card, not otherwise paid for by my employer.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR FASTEST REIMBURSEMENT  
FAX TO 203.234.1139  
OR MAIL TO:  
Group Benefit Administrators of Connecticut  
23 Maiden Lane, North Haven, CT 06473**