



HAMDEN BOARD OF EDUCATION SECTION 125 PLAN

Enrollment and Compensation Reduction Agreement for Dependent Care Assistance Plan

Name: _____

Address: _____

Social Security Number: _____

Commencing with the payroll period beginning after the later of the Effective Date of the Dependent Care Assistance Plan and the date I return this form to my employer, I hereby enroll for certain benefits under the:

Hamden Board of Education Dependent Care Assistance Plan ("DCAP")
Check box and complete below to enroll in this DCAP.

I elect to receive the benefits provided to me under the DCAP by reducing my compensation by \$ _____ dollars per Plan Year (July 1 - June 30). But in no event shall my total compensation reduction for the year exceed a Maximum Benefit Amount of \$7,500 dollars. **[NOTE: The Maximum Benefit Amount for the DCAP is generally the lowest of (1) \$7,500, (2) your earned income, and (3) your spouse's earned income for the tax year.]** If you spouse is a full-time student, or you are married but elect to file a separate income tax return from your spouse, please contact Human Resources before completing this form because special limits apply in your case.

I elect to reduce my compensation by the annual amount set forth above, in installments to be deducted from my pay according to the Board of Education's payroll schedule applicable to me, beginning on the commencement date. Any previous compensation reduction agreement under the Plan is hereby revoked. The compensation reduction shall continue for each succeeding payroll period until this agreement is changed or revoked, or until I reach my Maximum Benefits Amounts.

I have read and I understand the attached sheet.

Date

Name of Employee