

DCRF MONTHLY REIMBURSEMENT FORM

Verizon CWA IBEW 2213

DCRF Monthly Request Form for the Month of _____, 200_
(Print in Ink) (Make copies of this form to use each month per child, per provider)

Employee Name		Social Security #:		
Home Address:		City	State	Zip
Home Telephone No:		Cell #		
Work Address:		City	State	Zip
Work Telephone No:		E-mail Address		
<input type="checkbox"/> CWA LOCAL No.		<input type="checkbox"/> IBEW 2213		<input type="checkbox"/> MANAGEMENT
Dependent Name <small>(one per form)</small>		Dependent Date of Birth		Age

EMPLOYEE SECTION
EXPENSES INCURRED ARE NOT REIMBURSABLE when NOT AT WORK
i.e. vacation, Incidental absence, Disability absence, EWD, Paid Company Holidays are not reimbursed.

Week Ending Friday	Indicate Dates Care was Provided	Indicate Dates Employee had off from work	Indicate Amount Paid less days off	Check below indicating type of Dependent Care
			\$	<input type="checkbox"/> Day Care/Nursery/Pre-K
			\$	<input type="checkbox"/> Before & After School Care
			\$	<input type="checkbox"/> Pre-School
			\$	<input type="checkbox"/> Adult/Disability Care <input type="checkbox"/> Elder Care
			\$	<input type="checkbox"/> Summer Camp
Total Monthly Expense			\$	<input type="checkbox"/> Other (explain)

I certify the accuracy of the above number of days off during my work week dates of provider service and that the above payments were made by me to the dependent care provider

Employee Signature: _____ Date _____

CARE PROVIDER PLEASE SIGN BELOW

Provider Name	Provider's SS#
Provider's Address	Tax ID #
Provider's Phone No:	Provider's License

I certify that the above amounts of monies were received for services rendered, and I am responsible for reporting these monies to the IRS AS INCOME.

Provider's or Authorized Signature: _____ Date _____

How to complete this form

- Employees must complete this form in its entirety. One form for each dependent and each provider. Only original signatures & reimbursement forms will be accepted. Photocopies or faxed copies will not be paid.
- Attach receipts when available for the month indicated above. If receipts are not available, your Care Provider must sign and complete the Care Provider Section of this form.
- All requests for reimbursement **must be received PRIOR TO THE SECOND FRIDAY OF EACH MONTH. Requests received after the second Friday of each month will not be paid.** Submit expenses for services rendered after incurred and paid.
- Reimbursement for dependent children ceases on the last day of the month prior to the month in which the child turns 13 years old.

Return this Monthly Reimbursement Form via Regular U.S. MAIL to:
VERIZON, NY/NE Regional Work and Family Committee, Sajdah Muhammad, 240 East 38th Street, Room 1567, New York, NY 10016. IF YOU HAVE QUESTIONS CONCERNING YOUR MONTHLY REIMBURSEMENT EXPENSES CONTACT THE FUND ADMINISTRATOR AT 646 227-6878