Verizon CWA IBEW 2213
REQUEST FOR DCRF MONTHLY REIMBURSEMENT

For the Month of _____

Employee Name: _____ Last Name _____ First Name			Emoloyee ID # :
Home Address:	City :	State :	Zip :
Home Telephone # :	Personal Cell # :		
Work Address:	City :	State :	Zip :
Work Telephone # :	Work e-mail Address :		

Check one of the below boxes to indicate your affiliation with Verizon

☐ CWA LOCAL # : _____	☐ IBEW 2213	☐ MANAGEMENT	☐ OTHER _____
Dependent Name :	Dependent Date of Birth* :		Age* :

EMPLOYEE SECTION

*** You may request reimbursement for each day your child is at care. You do not have to figure your expenses for each day during a short, temporary absence from work, such as for vacation or a minor illness, if you have to pay for care anyway. An absence of 2 weeks or less is a short, temporary absence for the purpose of this form.**

Employee must indicate Week Ending Friday Periods below	Employee must Indicate Dates Care was Provided	Employee must Indicate Dates Employee had off from work (see above)*	Employee must Indicate Amount Paid less days off
			$
			$
			$
			$
			$
Enter total Monthly Paid Expense here >			$

Check below indicating type of Dependent Care

- ❑Day Care/Nursery/Pre-K
- ❑Before & After School Care
- ❑Pre-School
- ❑Adult/Disability Care
- ❑Elder Care
- ❑Summer Care
- ❑Day Camp
- ❑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 COMPLETE AND PLEASE SIGN BELOW

Print Provider Name:	Provider's Phone # :		
Provider's Address :	City :	State :	Zip :
Tax ID # :	Registration # :		

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.

Care Provider's Signature : **Date :**

_____ _____

See reverse for instructions for completion of this form

How To Complete the DCRF Reimbursemnet Form

Employees upon confirmation of enrollment must complete a request for reimbursement form each month. **Each request for reimbursement must contain an original signature by the care provider and employee.** A request for reimbursement form must be used for each care provider when multiple care providers are used.

Attach original receipts or copy of cancelled check or money order when submitting this form.

Employees must notify the Fund Administrator if an enrolled dependent's status has changed as well as all changes regarding the care provider.

Employee requests for reimbursement must be submitted by mail to the fund administrator and postmarked no later than the second Friday of each month. Deadline dates for plan year 2017 are noted below.

	January	February	March	April	May	June
Deadline Date	2/10/2017	3/10/2017	4/14/2017	5/12/2017	6/09/2017	7/14/2017
	July	August	September	October	November	December
Deadline Date	8/11/2017	9/08/2017	10/13/2017	11/10/2017	12/08/2017	1/12/2018

Fund Administrator:

Beverly Steele
Telephone Number 516-797-3872

Return this form via U.S. Mail to:

NY/NE Regional Work & Family Committee
c/o Beverly Steele, Fund Administrator
Room 200-A
120 Hicksville Rd.
Massapequa, N.Y. 11758

Appeals Process

(Enrollment or Monthly Reimbursement)

Appeals must be received within 45 days of your written notification of denial of enrollment or within 45 days of a denial of reimbursement for expenses.

Appeals must be in writing and submitted to:

NY/NE Regional Work & Family Committee
c/o Beverly Steele, Fund Administrator
Room 200-A
120 Hicksville Rd.
Massapequa, N.Y. 11758

You must enclose all necessary documentation when filing an appeal.

Include a valid reach number and current e-mail address for a response.