Verizon CWA IBEW 2213
REQUEST FOR DCRF MONTHLY REIMBURSEMENT

For the Month of ______________

Employee Name: ____________ (Last Name) ____________ (First Name)			Emoloyee ID # : VZ 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 # :	Provider's SS # :	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.

Provider's or Authorized Signature : ______________________ Date : ____________

See reverse for instructions for completion of this form

How to complete this form

Employees must complete this form in its entirety. One form per provider. Only original signatures & reimbursement forms will be accepted. Photocopies or faxed copies will not be accepted unless requested by Fund Administrator.

Employee and Care Provider must sign and complete the Care Provider Section of this form. Attach original receipts or copy of cancelled check or money order when available.

Employee requests for reimbursement must be POSTMARKED no later than the SECOND FRIDAY OF EACH MONTH.

Return this Monthly Reimbursement Form via Regular U.S. MAIL to:

VERIZON NY/NE Regional Work and Family Committee
c/o Beverly Steele, Fund Administrator
240 East 38th Street, Floor 15, New York, NY 10016.

***Reimbursement for dependent children ceases on the last day of the month prior to the month in which the child turns 13 years old.**

Appeal Process

(Enrollment / Monthly Reimbursement)

Appeals must be submitted in writing to the NY/NE Regional Work and Family Committee with details of your situation. Enclose all necessary documentation. Your appeal must be received by the committee within 45 days of your written notification of denial of enrollment or within 45 days of non payment of your dependent care expense.

Submit all appeal to:

VERIZON NY/NE Regional Work and Family Committee
c/o Beverly Steele, Fund Administrator
240 East 38th Street, Floor 15, New York, NY 10016.