LOCAL 2/Hospitality Industry Child & Elder Care Plan
209 Golden Gate Avenue, San Francisco, CA 94102 • 415-864-0506 • ChildElderPlan@local2benefits.org

Elder/Disabled Care Benefit Affidavit — Plan Year 2021 - 2022

Last Name	First Name	Social Security Number
Street Address/P.O. Box		**Address Change**: ☐ Yes ☐ No
City	State + Zip Code	Email
Home Phone	Cell Phone	Cell Phone Company
Name of Elder/Disabled Relative	Relative's Birth Date	Relationship to You

Please answer each statement below.

1. I use this benefit to pay someone to care for my relative so I can go to work. ____Yes ____ No
2. I and/or my spouse claim this relative as a dependent in tax year 2021 and 2022. ____Yes ____ No
3. I **pay** at least $160 per month for the care of my relative. ____Yes ____ No
4. I **pay**: ___a relative ___friend or neighbor ___caregiver. This person is <u>not</u> my spouse or the spouse of my relative. ___True ___False
5. Name of person I **pay** _____Telephone _____
6. The person I **pay** is my child or stepchild under the age of 19. ____Yes ____ No
7. I and/or my spouse claim the person as a dependent at the end of this tax year. ____Yes ____ No
8. The elder/disabled relative spends at least 8 hours per day in my home. ____Yes ____ No
9. **If the person I pay to take care of my relative changes, I will notify the Plan office within 30 days**. ____Yes ____ No

I understand that my signature below indicates my agreement to the following:

- The Local 2/Hospitality Industry Child & Elder Care Plan (Plan") reserves the right to contact and obtain documentation from the service provider listed on this affidavit and previously submitted affidavits to verify any services rendered and/or receipts paid.
- I will notify the Plan office within 30 days if there is a change in the service provider, in my address, or if the relative named above moves outside one of the 15 approved Northern California counties.
- I will notify the Plan office within 30 days if the elder/disabled relative named above no longer requires provider services due to death or improved medical condition.
- All information submitted by me to the Plan is truthful and accurate. I understand that falsifying any information is grounds for the Plan's termination of benefits and I will reimburse the Plan all money improperly paid to me.
- I grant the Plan my permission to photograph me, my child or relative and agree that these images may be used by the Plan, or by the individuals or entities related to the San Francisco Culinary, Bartenders and Service Employees Welfare Fund ("Welfare Fund"). I approve the Plan's and/or Welfare Fund's use of my relative's name for purposes of recognizing their achievements.
- I agree to all conditions and limitations of the Local 2/Hospitality Industry Child & Elder Care Plan and the Welfare Fund.

Signature _____ **Date**_____

FOR OFFICE USE ONLY

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☐ 1st Quarter (September, October, November)
☐ 2nd Quarter (December, January, February)
☐ 3rd Quarter (March, April, May)
☐ 4th Quarter (June, July, August)

Reviewed By _____ Date _____

White Copy: Plan Office **Color Copy: Local 2 Member**