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

Informal Child 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 Child	Child's Birth Date	Relationship to You

Please answer each statement below.

1. I use this benefit to pay for child care so I can go to work. ____Yes ____ No
2. I and/or my spouse claim this child as a dependent in tax years 2021 and 2022. ____Yes ____ No
3. I pay $100 or more a month for the care of my child. ____Yes ____ No
4. I **pay**: _____a relative _____friend or neighbor _____babysitter. This person is not my spouse. ____True ____False
5. Name of child care provider 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 I pay as a dependent at the end of this tax year. ____Yes ____ No
8. **If the person I pay to take care of my child 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, in the dependent or custody status of the child named above or if the child named above moves outside one of the 15 approved Northern California counties.
- 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 child/children's name(s) 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**