

LOCAL 2/Hospitality Industry Child & Elder Care Plan

209 Golden Gate Avenue, San Francisco, CA 94102 • 415-864-0506 • ChildElderPlan@local2benefits.org

Newborn Benefit Affidavit

Plan Year 2021 - 2022

Last Name	First Name	Social Security Number
Street Address/P.O. Box		Address Change: <input type="checkbox"/> Yes <input type="checkbox"/> 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.

- I use this benefit to pay for child care so I can go to work. Yes No
- I and/or my spouse claim this child as a dependent in tax years 2021 and 2022. Yes No
- Some or all of the money I receive from this benefit is used for baby supplies. Yes No
- I spend \$125 or more a month to pay a child care provider. Yes No
- Name of child care provider _____ Telephone _____
- The person I pay is is not my spouse. Yes No
- I and/or my spouse claim the person I pay as a dependent at the end of this tax year. 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

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

Reviewed By _____ Date _____

MISSING:

- Birth Certificate
- Social Security Card