

## DEPENDANT CARE Claim Form

ease return this form to CUPE BC (ac	counting@cupe.bc.ca) along with a	copy of the Caregi	ver invoice/ receipt of	payment. Refer to the fu	ll policy for more details
EMBER'S NAME:			CI	JPE LOCAL:	
First	Last			of L LOCAL.	
ODRESS:					
Street	City		Postal Code		
NION EVENT:		DATE:			
HEDULED WORKING HRS (FROM	м/то):				
				_	
		TELEPHONE:			
the Caregiver above someone o					
as this expense covered by fund		NO	If YES, please att	ach additional inform	ation
DEPENDANT CARE PROVIDE  Name of I	Age	Relationship to Member			
	- GP G1.04.11.1	7.85	-		<u>.                                    </u>
COMPLETE THE TABLE BELO	MA/-		I		
2. COMPLETE THE TABLE BELOW:  Date Of Claim  Hours Of Dependant Care Required  No. of Hrs  Rate Per Ho					Daily Claim
Date of claim	(From/To)		140.011113	Nate Fer Floar	Duny Claim
				Total Claim \$	
I recognize that <b>only</b> claims fo	or Dependant Care outside of m	ıy regular workin	g hours may be mad	le as per CUPE BC Expe	ense Policy.
ember's Signature	Date		Approve		

Dependant Care, if required, will be paid outside of regular working hours to a maximum of \$20.00/hr (not to exceed \$300.00 /day). Exceptional circumstances and/or extra costs, require prior approval by the Secretary-Treasurer. Receipts must be attached for each Dependant Care claim.