BUFFALO LABORERS' WELFARE FUND (the "Fund")

DAY CARE REIMBURSEMENT

PARTICIPANT INFORMATION

Participant's Name (print) SS# **XXX - XX -**

Phone Number ( ) Date of birth / /

Street Address City State Zip

DAY CARE EXPENSES

Dependent's Full Name	Relationship	Date(s) of Service	NYS Certified Day Care Provider	Amount Paid
Total Reimbursement Due:				

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses listed above have been incurred by me and to the best of my knowledge qualify for reimbursement under the Fund's Summary Plan Description. I have read and understand the preceding sections of this form and I have attached the required supporting documentation. I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to the above claims. I will not seek reimbursement under any dependent care plan or any other source. I understand that the expense for which I am reimbursed may not be used to claim any Federal income tax deduction or credit.

Employee Signature_____Date_____

Employee: Return completed form to the Buffalo Laborers' Welfare Fund at 25 Tyrol Drive, Suite 200, Cheektowaga, NY 14227

BUFFALO LABORERS' WELFARE FUND

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

Dependent Care Expenses: Complete the requested additional information for dependent care expenses on the attached form, and attach the original itemized bill from the care giver, nursery school, day care center, etc. **You must also include proof that your spouse is working or attending school at the time of the day that the day care was provided.**

TIMING: In order to make a claim for a Day Care reimbursement benefit, you must submit the claim and all required proof **within 90 days after the end of the calendar year (April 1st)** in which the related expense was incurred.

FRAUDULENT OR INCORRECT INFORMATION:

Your or your Dependent's benefits under the Plan may be denied, suspended or discontinued at any time and for any length of time (including permanently) by duly authorized representatives of the Fund office, the Trustees (or any of their designees) in their sole and absolute discretion if you or your Dependent fail to submit the requested information or proof, make a false statement, or furnish fraudulent or incorrect information (including, for example, submitting fraudulent or altered bills in order to receive a day care reimbursement).

The Fund has also adopted a rule that provides that, if a participant or beneficiary makes a false statement or furnishes false or fraudulent information (such as fraudulent or altered bills in order to receive reimbursement for a day care reimbursement), at a minimum (in addition to any action taken under the preceding paragraph), the Fund will deduct $500 from the participant's Health Care Account for a first offense and $1,000 for a second offense.