



## Family or Dependent Care Subsidy

|                          |                  |
|--------------------------|------------------|
| <b>Name of Claimant:</b> | <b>Local No.</b> |
|--------------------------|------------------|

**CUPE only reimburses expenses in excess of regular fees.** (e.g. if your regular fees are \$30.00 per day and attendance at the CUPE function requires you to pay \$40.00, you would therefore claim the “excess fee” of \$10.00). **You may claim up to \$50.00 per day – receipts must be attached.** Please indicate the dates for expenses incurred, and the **excess** daily cost.

|  |
|--|
| <b>Name of Function or Conference:</b> |
|--|

| DATE         | COST (per day) |
|--------------|----------------|
|              |                |
|              |                |
|              |                |
|              |                |
| <b>TOTAL</b> | <b>\$</b>      |

Cheque to be made payable to: **Claimant**

**Local Union**

|                         |
|-------------------------|
| <b>Mailing Address:</b> |
|                         |
|                         |

\_\_\_\_\_  
*Signature of Claimant*

(1) \_\_\_\_\_

(2) \_\_\_\_\_

*signatures of 2 officers of the Local,  
one of whom is not the claimant*

**This form must be completed and forwarded no later than 30 days following the dates claimed to:**  
**CUPE Ontario**  
**80 Commerce Valley Dr. E., Suite 1**  
**Markham , ON L3T 0B2**  
**Phone: 905-739-9739 Fax: 905-739-9740**

|                       |
|-----------------------|
| <b>Cheque #</b> _____ |
| <b>Date:</b> _____    |