



## Family or Dependent Care Subsidy

Name of Claimant:

Local No.

**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.

Name of Function or Conference:

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

Cheque to be made payable to: Claimant

Local Union

Mailing Address:

\_\_\_\_\_  
*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**

Cheque # \_\_\_\_\_

Date: \_\_\_\_\_