



Family or Dependent Care Subsidy

Name of Claimant:	Local No.
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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:
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DATE	COST (per day)
TOTAL	\$

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: _____