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)
TOTAL	**$**

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

Local Union ☐

Mailing Address:

_____ **(1)** _____

Signature of Claimant

(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: _____