

To assist in processing - Please write "DCRF" on the bottom left of the envelope

**Verizon CWA IBEW 2213**  
**REQUEST FOR DCRF MONTHLY REIMBURSEMENT**

For the Month of \_\_\_\_\_

Employee Name: Last Name _____ First Name _____		Employee ID # : _____	
Home Address: _____		City : _____	State : _____ Zip : _____
Home Telephone # : _____		Personal Cell # : _____	
Work Address: _____		City : _____	State : _____ Zip : _____
Work Telephone # : _____		Work e-mail Address : _____	
<b>Check one of the below boxes to indicate your affiliation with Verizon</b>			
<input type="checkbox"/> CWA LOCAL # : _____	<input type="checkbox"/> IBEW 2213	<input type="checkbox"/> MANAGEMENT	<input type="checkbox"/> OTHER _____
Dependent Name : _____		Dependent Date of Birth* : _____ Age* : _____	
<b>EMPLOYEE SECTION</b>			
<b>* You may request reimbursement for each day your child is at care. You do not have to figure your expenses for each day during a short, temporary absence from work, such as for vacation or a minor illness, if you have to pay for care anyway. An absence of 2 weeks or less is a short, temporary absence for the purpose of this form.</b>			
Employee must indicate Week Ending Friday Periods below	Employee must Indicate Dates Care was Provided	Employee must Indicate Dates Employee had off from work (see above)*	Employee must Indicate Amount Paid less days off
			\$ _____
			\$ _____
			\$ _____
			\$ _____
			\$ _____
<b>Enter total Monthly Paid Expense here &gt;</b>		\$ _____	

Check below indicating type of Dependent Care

- Day Care/Nursery/Pre-K
- Before & After School Care
- Pre-School
- Adult/Disability Care
- Elder Care
- Summer Care
- Day Camp
- Other (explain) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify the accuracy of the above number of days off during my work week dates of provider service and that the above payments were made by me to the dependent care provider.

**Employee Signature:**

**Date:**

**Request for reimbursement must contain an ORIGINAL signature by the care provider and employee.**

**CARE PROVIDER COMPLETE AND PLEASE SIGN BELOW**

Print Provider Name: _____		Provider's Phone # : _____	
Provider's Address : _____		City : _____	State : _____ Zip : _____
Tax ID # : _____		Registration # : _____	

I certify that the above amounts of monies were received for services rendered, and I am responsible for reporting these monies to the IRS AS INCOME.

**Care Provider's Signature :**

**Date :**

**Make sure you include your receipt and sign your reimbursement form.**

**Thank You**

# How To Complete the DCRF Reimbursement Form

Employees upon confirmation of enrollment must complete a request for reimbursement form each month. **Each request for reimbursement must contain an original signature by the care provider and employee.** A request for reimbursement form must be used for each care provider when multiple care providers are used.

Attach original receipts or copy of cancelled check or money order when submitting this form.

Employees must notify the Fund Administrator if an enrolled dependent's status has changed as well as all changes regarding the care provider.

Employee requests for reimbursement must be submitted by mail to the fund administrator and postmarked no later than the second Friday of each month. Deadline dates for plan year **2026** are noted below.

	January	February	March	April	May	June
Deadline Date	2/13/26	3/13/26	4/10/26	5/8/26	6/12/26	7/10/26
	July	August	September	October	November	December
Deadline Date	8/14/26	9/11/26	10/9/26	11/13/26	12/11/26	1/8/27

**Fund Administrator:**

Beverly Steele

**Return this form via U.S. Mail to:**

NY/NE Regional Work & Family Committee  
c/o Beverly Steele, Fund Administrator  
Room 200-A  
120 Hicksville Rd.  
Massapequa, N.Y. 11758

## Appeals Process

**(Enrollment or Monthly Reimbursement)**

Appeals must be received within 45 days of your written notification of denial of enrollment or within 45 days of a denial of reimbursement for expenses.

**Appeals must be in writing and submitted to:**

NY/NE Regional Work & Family Committee  
c/o Beverly Steele, Fund Administrator  
Room 200-A  
120 Hicksville Rd.  
Massapequa, N.Y. 11758

You must enclose all necessary documentation when filing an appeal.

Include a valid reach number and current e-mail address for a response.