Commonwealth Of Massachusetts / National Association Of Government Employees
Health and Welfare Trust Fund
Dependent Care Assistance Program Reimbursement Form

Make sure that all sections are completed, that you and the provider have signed the form, and that all supporting documentation is included. If the form is incomplete it will be returned.

Member Information

Member Name: ____

Member Address: ____

Dependent Name: ____________________ Relationship: __________ DOB: __________

Dependent Name: ____________________ Relationship: __________ DOB: __________

Amount of Reimbursement Requested: ______________ Dates of Service (*from/to*) ______________

Member Signature: ______________________________ Date: __________

I request reimbursement for the attached expenses under the Dependent Care Assistance Program. I certify that these expenses meet the requirements of the Dependent Care Assistance Program as set forth in the Fund's Benefit Plan information booklet. Furthermore, I declare that these expenses have been incurred by me and have not been reimbursed from any other source nor do I expect them to be.

Provider Signature

Signature of Provider: ______________ Provider Email ______________

Total Paid: __________

Tax ID Number: ______________________ Form of Payment: Check Charge Cash
(Circle One)

AFFIDAVIT: I hereby certify that I provided adult or child day care services to the above individuals in accordance with the amounts and dates that are requested.

All claims for services each calendar year must be post marked not later than the following January 31st. No reimbursement will be issued retroactively for any claim received by the Commonwealth of Massachusetts/NAGE Fund Office after that date.

When submitting a claim for an eligible dependent care expense the following information is required. A receipt, an invoice marked "paid" or a written statement from the person or organization who provided the services on appropriate letterhead, which must include all of the following: the name of the child (ren) the services were provided for, the type of service provided, dates of service from/to, not payment dates (dependent care program is based on a calendar year), the total amount paid and the provider's complete address and signature. You must also include the provider's tax identification number or Social Security number, as well as any additional information that the Fund may request.

A receipt or written statement created by the member for the provider to sign, payment history, cancelled checks or past Dependent Care Assistance receipt forms are not accepted as proof of payment.

Any claim received missing any of the above information will be returned to the member. **Please note that the Commonwealth of Massachusetts/NAGE Health and Welfare Trust Fund will be required to report your reimbursement amount to both you and the IRS each year on an IRS From W-2.**

Commonwealth of Massachusetts/NAGE Fund Office
159 Burgin Parkway, Quincy, MA 02169
617-773-8947 - 1-800-641-0700 - fax 617-773-8637

It is illegal for a Fund member to willfully and knowingly misrepresent any fact for the purpose of securing benefits under any of the Fund's plans. Any member found by the Board of Trustees to have committed such a misrepresentation may immediately become ineligible for benefits, and will be required to reimburse the Fund for any benefits so obtained. The Fund Office will cooperate with law enforcement agencies investigating and prosecuting criminal complaints, including fraud or larceny.