

**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: \_\_\_\_\_ SS# \_\_\_\_\_

Member Address: \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Amount of Reimbursement Requested: \_\_\_\_\_

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: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_

**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.*

**Send this form to  
Commonwealth of Massachusetts/NAGE Fund Office  
159 Burgin Parkway, Quincy, MA 02169**

When submitting a claim for an eligible dependent care expense, you must include supporting documentation such as an invoice, a written statement or receipt from the person or organization who provided the service, having the name of child(ren) the services were provided for, the type of service provided, dates of service from/to (dependent care program is based on a calendar year) the total amount paid, and the signature of provider. Copies of cancelled checks or payment history statements are not accepted as proof of payment. You must also include the provider of care's name, address, and taxpayer identification or Social Security number, as well as any additional information that the Fund may request. **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 Form W-2.**

**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.**

***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.***