Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund
Administered by Wilson-McShane Corporation
3001 Metro Drive – Suite 500
Bloomington, MN 55425

Phone: (952) 854-0795
Fax: (952) 854-1632
Toll Free: (800) 535-6373

APPLICATION FOR DEPENDENT CARE REIMBURSEMENT

(Please copy for future use. This form must be signed, dated and sent along with your claim each time)

You must be an eligible participant of the Health and Welfare Fund in order to participate in the dependent care reimbursement benefit.

NAME _____ DOB _____

SSN _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ TELE _____

NAME OF ELIGIBLE DEPENDENT	RELATIONSHIP	DOB

PROOF OF ELIGIBLE DEPENDENT

- A copy of your marriage certificate or registered domestic partnership
- A copy of your child's birth certificate or legal adoption papers

You will only need to send in this documentation annually with your application. You will also need to provide proof of full-time student for each unmarried child between the ages of 19-23. See your Summary Plan Description and Plan Document for a detailed definition of qualified dependents (dependents not meeting these definitions will be denied for reimbursement).

PROOF OF COVERAGE

- A copy of your monthly insurance premium billing statement showing covered dependent's name(s).

If your insurance premium billing statement does not show the covered dependent's name(s), you must provide a statement from the insurance company showing the covered dependent(s) on the plan.

PROOF OF PAYMENT

- A copy of the money order
- A copy of the check and bank statement showing the check cleared your account
- Copy of the bank statement for automatic premium deduction
- Copy of spouse's payroll stub showing deduction for medical care insurance

Bank statements only need to show the participant's name and information relating to the medical care insurance payment – all other information may be blocked out.

AMOUNT OF REIMBURSEMENT: The Fund will reimburse you up to $225.00 per month, regardless of the number of dependents.

I understand the requirements of the dependent care reimbursement benefit and hereby apply.

_____ _____

SIGNATURE DATE