

**Bricklayers & Allied Craftworkers Local #3
Rochester Chapter
Health & Welfare Fund**

33 Saginaw Drive
Rochester, NY 14623

Phone: (585) 385-1160*Email: claimsroc@baclocal3ny.com***Fax: (585) 385-9119**

CHILD CARE APPLICATION

Name of Member_____

Address_____

Social Security Number_____

Name of Dependent(s)_____

Dependent Social Security No(s)_____

Child Care Provider_____

Employer Identification Number (EIN)_____

CERTIFICATION

I, the undersigned, do hereby attest that the bills and/or receipts I have submitted are valid provided by the Plan of the Bricklayers & Allied Craftworkers Local #3 Rochester Chapter Health & Welfare Fund. I do further grant the Administrator of said Fund permission to issue reimbursement from the individual reserve in my name in whole or in part in accordance with the provisions of the Plan.

Signature_____

Date_____

Pick Up Check ☐ (FRIDAY)

FOR OFFICE USE ONLY

4675:_____

Approved By:_____

Date Paid:_____