

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

1175 William Street  
Buffalo, NY 14206

Phone: (716) 842-1318 \*\*\*Email: [claimsbuf@baclocal3ny.com](mailto:claimsbuf@baclocal3ny.com)\*\*\*

**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 Buffalo 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

**FOR OFFICE USE ONLY**

4675:\_\_\_\_\_

Approved By:\_\_\_\_\_

Date Paid:\_\_\_\_\_