

email completed forms to: verizon.benefits.team@verizon.com

Verizon CWA IBEW 2213
REQUEST FOR DCRF MONTHLY REIMBURSEMENT

For the Month of _____

Employee Name: _____ Last Name First Name		Employee ID # :	
Home Address:	City :	State :	Zip :
Home Telephone # :	Personal Cell # :		
Work Address:	City :	State :	Zip :
Work Telephone # :	Work e-mail Address :		
Check one of the below boxes to indicate your affiliation with Verizon			
<input type="checkbox"/> CWA LOCAL # : _____	<input type="checkbox"/> IBEW 2213	<input type="checkbox"/> MANAGEMENT	<input type="checkbox"/> OTHER _____
Dependent Name :		Dependent Date of Birth* :	Age* :
EMPLOYEE SECTION			
* You may request reimbursement for each day your child is at care. You do not have to figure your expenses for each day during a short, temporary absence from work, such as for vacation or a minor illness, if you have to pay for care anyway. <u>An absence of 2 weeks or less is a short, temporary absence for the purpose of this form.</u>			
Employee must indicate Week Ending Friday Periods below	Employee must Indicate Dates Care was Provided	Employee must Indicate Dates Employee had off from work (see above)*	Employee must Indicate Amount Paid less days off
			\$
			\$
			\$
			\$
			\$
Enter total Monthly Paid Expense here >			\$
Check below indicating type of Dependent Care			
<input type="checkbox"/> Day Care/Nursery/Pre-K <input type="checkbox"/> Before & After School Care <input type="checkbox"/> Pre-School <input type="checkbox"/> Adult/Disability Care <input type="checkbox"/> Elder Care <input type="checkbox"/> Summer Care <input type="checkbox"/> Day Camp <input type="checkbox"/> Other (explain) _____ _____ _____			
I certify the accuracy of the above number of days off during my work week dates of provider service and that the above payments were made by me to the dependent care provider.			
Employee Signature:		Date:	
Request for reimbursement must contain an ORIGINAL signature by the care provider and employee.			
CARE PROVIDER COMPLETE AND PLEASE SIGN BELOW			
Print Provider Name:		Provider's Phone # :	
Provider's Address :		City :	State : Zip :
Tax ID # :		Registration # :	
I certify that the above amounts of monies were received for services rendered, and I am responsible for reporting these monies to the IRS AS INCOME.			
Care Provider's Signature :		Date :	
_____		_____	
Make sure you include your receipt and sign your reimbursement form.			
Thank You			

How To Complete the DCRF Reimbursement Form

Employees upon confirmation of enrollment must complete a request for reimbursement form each month. Each request for reimbursement must contain an original signature by the care provider and employee. A request for reimbursement form must be used for each care provider when multiple care providers are used.

Attach original receipts or copy of cancelled check or money order when submitting this form.

Employees must notify the Fund Administrator if an enrolled dependent's status has changed as well as all changes regarding the care provider.

Employee requests for reimbursement must be submitted by email to the fund administrator no later than the second Friday of each month. Deadline dates for plan year **2026** are noted below.

	January	February	March	April	May	June
Deadline Date	2/13/26	3/13/26	4/10/26	5/8/26	6/12/26	7/10/26
	July	August	September	October	November	December
Deadline Date	8/14/26	9/11/26	10/9/26	11/13/26	12/11/26	1/8/27

Fund Changes: Effective 2/1/26

Paperwork must be submitted electronically to: verizon.benefits.team@verizon.com

- Please put: **DCRF Reimbursement** in the subject line of the email

Appeal Process:

Appeals must be received within 45 days of your written notification of denial of enrollment or within 45 days of a denial of reimbursement for expenses.

Appeals must be submitted to: verizon.benefits.team@verizon.com

- Please put: **DCRF Appeal** in the subject line of the email
- You must attach all necessary documentation when filing an appeal.
- Include a valid reach number and current email address for a response.