Local 2/Hospitality Industry Child & Elder Care Plan
209 Golden Gate Avenue, San Francisco, CA 94102 • 415-864-0506
www.local2benefits.org • ChildElderPlan@local2benefits.org

APPLICATION FORM PLAN YEAR 2025-2026

1

Last Name _____ First Name _____ Social Security Number _____

Mailing Address _____ **Address Change?** ☐ yes ☐ no

City _____ Zip Code _____ Email _____

Cell Phone _____ Cell Phone Provider (Ex: AT&T, Cricket, T-Mobile) _____

2

Primary Language: ☐ English ☐ Spanish ☐ Cantonese ☐ Vietnamese ☐ Tagalog ☐ Mandarin ☐ Other: _____

Employer: _____ Job Classification: _____

3

1ST Choice Benefit

Name _____

Birth Date _____/_____/_____
month day year

Social Security Number _____

Relationship To You: _____

☐ Newborn
☐ Informal Child Care
☐ Pre-School
☐ School-Age Child Care
☐ Youth Program
☐ College Prep – 12th grade in Sept. 2025
☐ Elder/Disabled Care

BCS _____

2ND Choice Benefit

Name _____

Birth Date _____/_____/_____
month day year

Social Security Number _____

Relationship To You: _____

☐ Newborn
☐ Youth Program
☐ College Prep – 12th grade in Sept. 2025

BCS _____

Direct Deposit Info

Name of Bank _____

Routing # _____

Account # _____

Include a copy of check or statement with information above

Other Children Under 18 years old?

Name: _____

Birth Date: _____/_____/_____
month day year

Name: _____

Birth Date: _____/_____/_____
month day year

4

I, the undersigned, acknowledge:
I am responsible for screening, interviewing, and selecting all care providers.• I accept the Local 2/Hospitality Industry Child & Elder Care Plan, my employer, and the Trustees of the SF Culinary, Bartenders and Service Employees Welfare Fund bear no liability for the care arrangement I make.• I understand the financial reimbursement I am awarded may be considered taxable income and if so, I will receive a tax Form W-2 at the end of the tax year.• I understand falsifying the information provided here, on my financial reimbursement affidavit, or any other Plan forms or documents constitutes fraud and is grounds for termination of benefits and reimbursement of money improperly paid to me.• I agree to all conditions and limitations in the Local 2/Hospitality Industry Child & Elder Care Plan.

Printed Name: _____ **Signature:** _____ **Date:** _____

FOR OFFICIAL USE ONLY:

First Time: _____

Initials: _____ Date: _____

MISSING:

BC	MD	W4
POA	IHSS	POP
SSN	MARRIAGE	Affidavit
CC LIC/QF		DD