



Local 2/Hospitality Industry Child & Elder Care Plan

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www.local2benefits.org • ChildElderPlan@local2benefits.org

APPLICATION FORM

PLAN YEAR 2026-2027

1

Last Name _____ First Name _____ Social Security Number _____

Mailing Address _____ Address Change? yes no

City _____ Zip Code _____ Email _____

Cell Phone _____

2

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

Employer: _____ Job Classification: _____

3

1st Choice Benefit	2nd Choice Benefit	Direct Deposit Info
Name _____	Name _____	Name of Bank _____
Birth Date ____/____/____ month day year	Birth Date ____/____/____ month day year	Routing # _____
Social Security Number _____	Social Security Number _____	Account # _____
Relationship To You: _____	Relationship To You: _____	<i>Include a copy of check or statement with information above.</i>
<input type="checkbox"/> Newborn <input type="checkbox"/> Informal Child Care <input type="checkbox"/> Pre-School <input type="checkbox"/> School-Age Child Care <input type="checkbox"/> Youth Program <input type="checkbox"/> College Prep – 12 th grade in Sept. 2026 <input type="checkbox"/> Elder/Disabled Care	<input type="checkbox"/> Newborn <input type="checkbox"/> Youth Program <input type="checkbox"/> College Prep – 12 th grade in Sept. 2026	Other Children Under 18 years old?
BCS _____	BCS _____	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	DE4	DD