



# Local Membership Expense Claim Form

Member data  BPS  CAAT  OPS  EBM  Other

Name: \_\_\_\_\_ Union ID: \_\_\_\_\_ Local: \_\_\_\_\_

Address: \_\_\_\_\_

Postal code: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ Telephone: (work) \_\_\_\_\_

Date mm/dd/yyyy	Explanation/Reason for claim Describe union function attended	Own Time 802	Wages 804	Travel (see page 2) 702			Meals 704				Family care (see page 2) 805			Hotel/Phone 705	Misc. expenses parking etc.	Receipts attached		For Accounting use only
				# of People	KMs Driven	Amount (total)	B \$13	L \$19	D \$29	Amount (total)	From (hour)	To (hour)	Amount (total)			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Totals																		

*This expense report form is to be completed in full. Please type or print neatly.*

Less advance: \_\_\_\_\_

Balance owing to member (refund to OPSEU): \_\_\_\_\_

Authorized by chairperson/staff: \_\_\_\_\_

Payment approved by: \_\_\_\_\_

Cheque #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: (mm/dd/yyyy) \_\_\_\_\_

*Note: In order to avoid unnecessary delay in processing, please check to see that:*  
 (a) this form is properly completed;  
 (b) all required receipts have been attached. Forward an original copy to OPSEU. Retain a copy for your records.



# Local Membership Expense Claim Form

## General information

1. This form must be signed by the claimant and must be accompanied by the necessary original receipts (e.g. last portion of air fare, hotel bill/receipt.) Expense details should be listed chronologically and should include a brief description of the purpose/reason for the expense.
2. Claims must be submitted no later than ninety (90) days from the last date for which expenses are claimed and must be accompanied by a refund of the unused expense advance where applicable.
3. Any advances received should be deducted from the total expenses to arrive at the balance owing from/to OPSEU.

## Meals

(a) Where a member/representative is on approved union business, he/she may be entitled to reimbursement for meals as per OPSEU policy.

## Hotel/Phone (accommodation)

- (a) Where members are out of town on union business and/or an overnight stay is necessary, they are allowed to claim accommodation.
- (b) Reimbursement will be made only for the hotel charges for room, tax and phone calls made on union business or otherwise allowed under the expense policy. Any other charges appearing on the hotel bill will not be reimbursed.

## Travel

- (a) A member will be reimbursed for the actual cost incurred for travel by public transportation. As per the policy of the Union, the most economical means of transportation should be used.
- (b) The rental of automobiles must be approved in advance by the OPSEU Vice-President/Treasurer.
- (c) Where members are required to use their private vehicles, they may claim for such travel at the current rate. The total distance travelled and destination points are to be indicated on the expense form.
- (d) No reimbursement will be made for any expenses incurred where the appropriate prior authorization has not been obtained.

KM	Name of passenger(s) please print	Local number
Single 55¢		
1 passenger 60¢		
2 passengers 65¢		
3 passengers 70¢		
4 passengers 75¢		

## Family Care (Child/Elder/Dependant)

Members are entitled to reimbursement of reasonable costs of family/dependant care provided by someone other than their partners /spouses as a result of absences from home arising from the conduct of union business. Such allowances are not intended to reimburse the claimant for dependant/family expenses that they would have normally incurred as a result of employment except where the absence exceeds the normal work day or week.

Family/Attendant care will be reimbursed at the rate of \$10.00 per hour to a maximum of \$160.00 per 24 hour period and must be signed by the care provider(s). Please specify hours claimed for each day.

Members who bring children to union events will be entitled to single accommodation and meal expenses. Claims for these expenses should also be included in the family care column of the form and described appropriately.

Important: please fill out family/attendant care claims (yellow and white separately)

<b>Family/Attendant care claims</b> <i>Please complete for all family care claims (please print)</i>
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Care Provider	
Name:	
Address:	
City:	Postal code:
Telephone:	
Signature of Care Provider: _____	
Children / Dependants	
Name	Age
Name	Age
Name	Age
Name	Age
Member confirmation <i>I affirm that without such family care I would have been unable to attend this OPSEU activity.</i>	

Signature: \_\_\_\_\_ Date: mm/dd/yyyy \_\_\_\_\_