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New Group Participation Information Form

The United Employees Benefit Trust (UEBT) is a self-funded ERISA-regulated, multiemployer health and welfare fund. When a new bargaining group or new employer contacts the UEBT about possible participation, the UEBT seeks to gather basic information about the group. The UEBT will use this information in determining whether to accept the group for participation. All participation requests are subject to review and approval by the Board of Trustees.

1. **Information about the Employer**
   a. Name: _____
   b. Location: _____
   c. Nature of Business: _____
   d. Does the Employer already have employee's participation in the UEBT? Yes No
   e. Contact Person: _____
2. **Bargaining Representative**
   a. Is the group represented by a labor organization? Yes No
   b. Labor Organization:
      Name: _____
      Location: _____
      Contact Person: _____
3. **Information about Group**
   a. Approximate number of employees in group: _____
   b. Bargaining unit description: _____
      _____
      _____
   c. Location(s) of employees: _____
4. **Demographic Information Distributed**
   a. Please provide a census showing:
      - Employee's Date of Birth
      - Marital Status
      - Number of Dependent Children
      - Ages of Dependent Children

5. **Current Health Coverage**

   a. What entity currently provides health coverage to the group? _____

   _____

   b. How long has the group been with this entity? _____

   c. Provide Summary of Benefits and Coverage (SBC) or other basic description of the benefits provided.

   d. Provide bargaining agreement language relating to health coverage.

   e. Is coverage under the Plan:

Mandatory Composite Coverage	Yes	No
Optional for employees	Yes	No
Optional for dependents	Yes	No

   f. Does employee have a cost share in the premium? $ _____ Yes No

   g. Does current coverage include employer-paid:

Medical	Yes	No	Time Loss	Yes	No
Dental	Yes	No	Vision	Yes	No
Life and AD&D	Yes	No			

6. **Reason for Seeking Different Coverage:** _____

   _____

   _____

7. **Desired Effective Date of Coverage and Plans:**

   a. Hours Worked: _____ Coverage Effective: _____

   b. Circle Desired Plan(s)

Medical Plans:	A5	A6	AV8	AV9	HDHP
Time Loss Plans:	TL2	TL4			
Dental Plans:	D5	D7	D8	Ortho	
Vision Plan:	V3				

Submitted By:

Employer	**Labor Union**
_____	_____
Name	Name
_____	_____
Title	Title
_____	_____
Contact Information	Contact Information