*220 S 27th St #B * Tacoma WA 98402*
(253) 474-1214 or (800) 223-2449
Fax: (253) 474-7180
Website: www.unitedemployees.org

Application for Participation / New Group 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. CBA Hour Requirement: ___________ ☐ worked ☐ compensated ☐ compensatory

b. Coverage Effective: ____

c. Select Desired Plan(s)

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

Submitted By:

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