NATIONAL IAM
BENEFIT TRUST FUND

PARTICIPATION AGREEMENT
for Health and Welfare Coverage

This Agreement is required for any new coverage or coverage change, and is an ADDENDUM to and a part of the Collective Bargaining Agreement between the Employer and the Union, as applicable. For non-bargained or Union staff employees, it allows for participation in the National IAM Benefit Trust Fund (Plan or Fund). **This form only has to be completed one time for the life of a group's participation in the Plan, unless there is a change that affects the information provided in Part I or Part II below** (not including rate adjustment at annual renewal).

INSTRUCTIONS - Please fill in all blanks and check appropriate boxes. Put "N/A" for "not applicable" in any blanks that do not apply. The Fund must receive and approve this Agreement before coverage will be provided. Please mail or email the signed Agreement to the Fund office along with a copy of the Collective Bargaining Agreement (CBA), if applicable. If you email the signed Agreement and CBA, please use following email address: **fundrep@iambtf.org**

I. THIS DOCUMENT COVERS THE FOLLOWING - This section identifies who is covered by this Agreement.

A. EMPLOYER NAME: _____

B. DESIGNATION – The following groups of people are covered:

☐ Bargaining ☐ Non-Bargaining ☐ Union Staff

at the following location(s): _____

If bargaining, identify any Union in addition to the IAM&AW: _____

(A separate Agreement must be completed by each Employer and each Union representing covered Employees)

C. ELIGIBILITY - The following classes of people are covered:

☐ Full time employees ☐ Part time employees

☐ Retirees (provide eligibility rules) ☐ Surviving spouses (provide eligibility rules)

☐ Other: Explain: _____

Explain If any limitation: _____

D. ORIENTATION PERIOD

1. Medical Coverage - Orientation period must be no more than 30 calendar days

☐ No orientation period ☐ Orientation period is 30 calendar days or less

If there is an orientation period, how long? _____

2. Other than Medical Coverage – No limit on orientation period

E. WAITING OR PROBATION PERIOD

1. Medical Coverage - Waiting or probation period must be no more than 90 calendar days

☐ No waiting or probation period ☐ Waiting or probation period is 90 calendar days or less

If there is a waiting or probation period, how long? _____

2. Other than Medical Coverage - No limit on waiting or probation period

F. COVERAGE FOR ANY NON-WORK PERIOD

☐ Coverage is not continued during any period when an employee is on leave

☐ Coverage is continued for the following types of leave, for the time period specified:

(Any coverage continuation for a period of leave that exceeds 12 months requires Trustee approval)

1. ☐ Medical leave of absence Maximum duration: _____

2. ☐ Layoff from work Maximum duration: _____

3. ☐ Union assignment Maximum duration: _____

4. ☐ Other (explain below) Maximum duration: _____

_____

II. COVERAGE ELECTION AND MONTHLY CONTRIBUTION - The following coverage is elected:

Beginning with the coverage effective date, the Employer agrees to remit a monthly contribution to the Fund for each coverage elected below**,** for each individual in an eligible class (the employer must remit the full contribution, but employee payroll deduction may be required for employee portion). Coverage will be provided for each eligible individual, their spouse or domestic partner, and other eligible dependents, as applicable.

*(**Note** – If more than one set of rates apply to any coverage election, show primary set below and identify the eligible class in section A. Then complete and initial Addendum to Participation Agreement form(s) to show other eligible classes and applicable contribution rates.* ☐ ***Mark box if one or more addendum is required for this Participation Agreement***.

A. ☐ **MEDICAL** Benefit option: _____ Coverage effective date: _____

ELIGIBLE CLASS: _____

☐ Two tier rates ☐ Three tier rates ☐ Four tier rates

Employee: _____ Employee: _____ Employee: _____

Family: _____ Employee+1: _____ EE+Spouse: _____

Family: _____ EE+Child(ren): _____

Family: _____

B. ☐ **DENTAL** Benefit option: _____ Coverage effective date: _____

ELIGIBLE CLASS: _____

Monthly rate: Employee: _____ Family: _____ Composite (legacy): _____

C. ☐ **VISION** Benefit option: _____ Coverage effective date: _____

ELIGIBLE CLASS: _____

Monthly rate: Employee: _____ Family: _____ Composite (legacy): _____

If Medical, Dental or Vision coverage is elected, Short Term Disability and Life and AD&D are also available

D. ☐ **DISABILITY** Benefit option: _____ Coverage effective date: _____

ELIGIBLE CLASS: _____

Monthly rate: _____ ***(Short Term Disability Income Coverage is an employee only benefit)***

E. ☐ **LIFE AND AD&D** Benefit option: _____ Coverage effective date: _____

ELIGIBLE CLASS: _____ Dependents covered? ☐

Benefit amount (employee only): _____ Monthly rate: _____

Dependent benefit amount (legacy): _____ Monthly rate: _____

III. PARTICIPATION PROVISIONS

A. DUE DATE - The Employer acknowledges that contributions must be paid to Fund by the first (1st) day of each coverage month and will be considered delinquent on the fifteenth (15th) day of that month. Any delinquent contributions are subject to the accrual of liquidated damages and interest under the terms of the Trust Agreement. Delinquency of more than one month could result in suspension of coverage.

B. RENEWALS - In general, the above rates will apply to the 12 month period that begins with the initial effective date of coverage. The employer will be sent an annual renewal letter prior to each anniversary date and agrees to adjust contribution rates for any subsequent year by the amount directed by the Fund. The Trustees reserve the right to modify or cancel any benefits under the Plan.

Fund Office Use Only: _____

C. COLLECTIVE BARGAINING AGREEMENT - The Employer and the Union are parties to a Collective Bargaining Agreement, where applicable. This Participation Agreement is an Addendum to any current or future CBA that applies while the Employer is participating in the Plan.

D. ACCEPTANCE OF THE TRUST AGREEMENT - The Employer and Union agree to be bound by the terms and provisions of the Trust Agreement for the Fund and all lawful amendments. It is specifically acknowledged that the Trust Agreement contains provisions concerning the imposition of liquidated damages, attorneys' fees and court costs.

E. DETAILS OF BENEFIT PROGRAMS - The Board of Trustees of the Fund has the sole discretion to determine all Plan benefits as described in the Summary Plan Descriptions and other governing Plan documents.

F. ENTIRE AGREEMENT - This document contains the entire agreement between the parties regarding the benefits under the Plan. No oral or written modification of this Agreement is binding on the Trustees of the Fund. No grievance procedure, settlement, or arbitration decision with respect to the obligation to contribute is binding on the Trustees of the Fund. The parties may terminate this Agreement by providing the Fund at least thirty (30) days advance written notice.

G. APPROVAL BY THE TRUST - This Agreement shall be implemented upon approval by the Board of Trustees of the Fund.

EMPLOYER AND UNION SIGNATURES – The undersigned agree to the terms noted above, and understand that participation in the Fund and coverage under the Plan is contingent on execution and receipt of this Agreement. This signed Agreement must be received within thirty (30) days of the coverage effective date. Any delay in receipt of the executed Agreement could result in delay of benefits for covered participants. *(**Note** - If signatures are required from more than one Employer or Union, please attach additional signature pages as necessary)*

Employer Name	Union Name
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Telephone Number	Telephone Number
Signature of Employer Representative	**Signature of Union Representative**
Print Name of Employer Representative	Print Name of Union Representative
Title	Title
Date Signed	Date Signed

Revised 8/2024