

CALIFORNIA EMPLOYERS ALLIANCE

UISWA WELFARE BENEFITS TRUST FUND
And
BARGAINING UNIT AGENCY PARTICIPATION IN UISWA

PLAN SPONSOR JOINER AGREEMENT

PLAN SPONSOR _____ CONTACT PERSON _____

SPONSOR'S ADDRESS _____

CITY, STATE, ZIP CODE _____

PHONE: _____ FAX: _____ Email: _____

TYPE OF BUSINESS: _____ YEARS IN BUSINESS: _____ #PARTICIPANTS: _____

I hereby apply for membership in the California Employers Alliance (CEA). As an owner/partner of the above named business, I am applying for sponsorship of the UISWA Welfare Benefits Trust Fund made available through the CEA. It is understood that acceptance as a member in the CEA does not provide for automatic acceptance for medical benefits. Under federal law participation in the CEA and the UISWA Welfare Benefit Trust Fund program is subject to written guidelines and approval by its Board of Trustees.

I hereby acknowledge that health care benefits are made available to us under a "Taft-Harley" trust through an agreement between the CEA and the UISWA. If this business elects to participate in the health care benefits, through membership in the CEA, this business agrees to become signatory to that Trust agreement between the U.I.S.W.A. and the CEA. Referenced Trust agreement is held at the office of the CEA for inspection during normal business hours and a copy will be made available for valid business purposes.

I also acknowledge and agree that a portion of the allowed benefit contribution includes CEA membership dues (if any) and any other fee for each participant in the benefit programs. The total amount stated for the selected program includes all premiums, dues, fees and administration charges.

I understand that each participant in the health program under the bargaining agreement must comply with the Article 1, Section 2 of the agreement by fulfilling the dues obligations.

I understand that the benefit contributions are invoiced and payable in advance of the coverage period. If payment is not received at least five (5) days prior to the next coverage period, benefits may be cancelled at the end of the period in effect.

PLAN SPONSOR: _____ DATE: _____

CEA/UISWA REPRESENTATIVE:  _____ DATE: _____

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And

BARGAINING UNIT AGENCY PARTICIPATION IN UISWA

PARTICIPANT JOINER AGREEMENT

PARTICIPANT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ PHONE _____ FAX _____ Email _____

CITY, STATE, ZIP CODE _____

SINGLE _____ MARRIED _____ JOB TITLE _____ PLAN SPONSOR _____

I am applying for participation in the UISWA Welfare Benefits Trust Fund. I understand that participation in the Welfare Benefits Trust Fund requires membership in the UISWA established by an agreement between my Plan Sponsor and the UISWA.

I hereby give my Plan Sponsor authorization to deduct from my wages and transmit to UISWA, such amount as may be lawful and properly adopted in the current agreement as the agency fees. This authorization shall be irrevocable for the period of one year following the date it is signed or until the current agreement expires between the U.I.S.W.A. Trust and the C.E.A., whichever occurs first. This authorization shall automatically renew from year to year. If I cancel my participation in the Trust benefit offering, this authorization will also be considered as terminated.

PARTICIPANT: _____ DATE: _____

CEA/UISWA REPRESENTATIVE:  _____ DATE: _____