NATIONAL IAM
BENEFIT TRUST FUND

PARTICIPATION AGREEMENT
for Health and Welfare Coverage

This Participation Agreement ("Agreement") is required for any new coverage or coverage change and is an addendum to the Collective Bargaining Agreement ("CBA") between the undersigned Employer and Union. For non-bargained ("NBU") or union staff employees, it allows for participation in the National IAM Benefit Trust Fund ("Plan" or "Fund"). **This form must be completed only once for the duration 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 (**excluding a rate adjustment at annual renewal).

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

A. EMPLOYER NAME: _____

B. BENEFIT CLASSES – The following groups of Participants are covered:

☐ Bargaining ☐ Non-Bargaining ☐ Union Staff & Affiliates

at the following location(s): _____

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

(The Employer must complete a separate Agreement for each Union representing covered Employees)

C. ELIGIBILITY – The following classes of Participants are covered:

☐ Full-time employees ☐ Part-time employees (attach eligibility rules)

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

☐ Other (Explain): _____

i. Orientation Period

Orientation Period must be no more than 30 calendar days

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

If an orientation period applies, indicate the number of calendar days: _____

ii. Eligibility Effective Date: After meeting eligibility requirements, the effective date for a Participant's group benefit coverage elections will be as follows:

☐ The first day of the month in which they are hired.
☐ The first day of the month following the month in which they are hired.
☐ The first day of the month following 30 days of employment.
☐ The first day of the month following 60 days of employment.

(**Note: this period cannot exceed 90 calendar days**)

D. COVERAGE DURING FAMILY AND MEDICAL LEAVE (FMLA)

Employer agrees that, if it properly grants an eligible employee leave under FMLA, Employer shall continue to have an obligation to make required contributions to the Fund under this Agreement and the CBA.

E. COVERAGE FOR CERTAIN NON-WORK PERIODS

☐ Coverage is continued for the following types of leave for the time period(s) specified:

1. ☐ Disability due to accident/illness* Maximum duration: _____
2. ☐ Layoff from work* Maximum duration: _____
3. ☐ Union assignment Maximum duration: _____
4. ☐ Military Leave of Absence Maximum duration: _____

Coverage continuation for disability due to accident/illness or layoff that exceeds 12 months requires Trustee approval.

II. COVERAGE ELECTION AND MONTHLY CONTRIBUTIONS

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

Note: *If more than one set of rates apply to any coverage election, the primary set is shown in section A and identifies the eligible class. Complete and initial any Addendums and/or Rate Exhibits to show other eligible classes and contribution rates and attach them to this Agreement. For separate retiree benefits, please complete an Addendum.*

☐ ***Mark box if one or more Addendums or Rate Exhibits are required for this Agreement.***

The following coverage is elected:

MEDICAL Benefit Option: A+ ☐ A ☐ B ☐ C ☐ D2 ☐ Effective Date: _____

ELIGIBLE CLASS: _____

Monthly rate: Employee: _____ EE+Child(ren): _____

EE+Spouse: _____ Family: _____

DENTAL Benefit Option: D001 ☐ D002 ☐ D003 ☐ D004 ☐ Effective Date: _____

ELIGIBLE CLASS: _____

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

VISION Benefit Option: Standard ☐ Enhanced ☐ 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.

SHORT TERM DISABILITY Benefit Option: _____ Effective Date: _____

ELIGIBLE CLASS: _____

Monthly Rate: _____ ***Short-Term Disability Coverage is an employee-only benefit.***

LIFE AND AD&D Benefit Option: _____ Effective Date: _____

ELIGIBLE CLASS: _____ Dependents Covered? (Legacy) ☐

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

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

III. PARTICIPATION PROVISIONS

1. **COLLECTIVE BARGAINING AGREEMENT.** The Employer and the Union are parties to one or more CBAs. This Participation Agreement is an Addendum to any current or future CBAs that apply while Employer participates in the Plan.

2. **ACCEPTANCE OF THE TRUST AGREEMENT.** Employer acknowledges that the Trustees of the Fund ("Trustees") have full discretion and authority to adopt rules and regulations governing eligibility and participation in the Fund. Additionally, Employer agrees to be bound to the governing Trust Agreement, Plan Document, Administrative Rules and Policies, or other documents (collectively, "Plan Documents") adopted by the Trustees in connection with the administration of the Fund. The Trustees have the authority to amend and interpret these rules and regulations without the consent of the Employer. Employer hereby acknowledges receipt of copies of the Plan Documents.

   Employer acknowledges that the Trustees have the sole discretion to determine all Plan benefits as described in the Summary Plan Descriptions and other governing Plan Documents. In the event of a conflict between any term or condition of this Agreement and the Trust Agreement, the Trust Agreement will control.

3. **CONTRIBUTIONS & DUE DATE.** Employer agrees and understands that it shall make timely contributions to the Fund by the first (1st) day of each coverage month, and that failure to do so shall subject Employer to attorney's fees, interest, liquidated damages, audit costs, and any other additional costs assessed under the terms of the Fund's Trust Agreement. Employer agrees and understands that contributions shall become delinquent if not received by the last day of the month in which contributions are due. For more information, refer to the Fund's Policy for the Collection of Delinquent Contributions and for Overpayments. Additionally, Employer understands and agrees that the Trustees may, on reasonable notice, conduct a payroll audit through their accountant or their representative of Employer's payroll records in connection with Employer's obligations under the CBA and under this Agreement. Employer further agrees to maintain

written records with respect to all employees covered by this Agreement sufficient to determine the benefits due or which may become due to such employees under the Fund's governing documents.

4. **RENEWALS.** In general, the rates from Section II (including those contained in attached Addendums and/or Rate Exhibits) shall apply to the 12-month period that begins with the initial effective date of coverage. 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.

5. **TERMINATION.** Either party may terminate this Agreement by delivering to the Fund Office at least thirty (30) days advance written notice. Such notice shall be deemed given if made (1) via certified mail with return receipt requested or (2) by electronic mail, provided that confirmation of receipt is given by Fund staff. Such notice shall be effective the first day of the following month after it is received by the Fund Office. Upon termination, Employer shall give written notice to all covered participants whose coverage is terminated.

   This Agreement shall automatically terminate, with no notice required to either party, upon the termination of the underlying CBA, in which case the termination date of this Agreement shall be the same termination date of the underlying CBA.

6. **ENTIRE AGREEMENT.** This document constitutes the entire agreement between the parties regarding the benefits under the Plan. No oral or written modification of this Agreement by the Parties is effective without the approval of the Trustees.

7. **APPROVAL BY THE TRUSTEES:** This Agreement is not effective until it is executed by an authorized representative of the Union, accepted by the Trustees, and a fully executed copy is on file with the Fund Office at 99 M Street SE, Suite 600, Washington, D.C., 20003. This signed Agreement must be received by the Fund Office within thirty (30) days of the coverage effective date. Any delay in receipt of the executed Agreement may delay benefits for covered participants.

IN WITNESS WHEREOF, the undersigned Parties have caused this Agreement to be duly executed by their respective duly authorized representatives.

Note *- If signatures are required from more than one Employer or Union Representative, 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