

PROPOSAL REQUEST

(400 Employees or more)

We appreciate your interest in the National IAM Benefit Trust Fund (BTF). Please submit the BTF Proposal Requests to [fundrep@iambtf.org](mailto:fundrep@iambtf.org). For Medical and Prescription Drugs (Rx) proposals, allow 7-10 business days after all required information is received for processing.Allow up to 48 business hours for non-Medical and Rx proposals to be processed.

Medical and Rx Proposal Only:

*Medical proposals may be subject to Board of Trustees Approval depending on the group’s claims experience.*

**Below is a list of documents needed to provide a proposal:**

* Census list with employee names and column with bargaining/non-bargaining
* Medical and Rx claims experience (last 3 years)
* Large claims over $75k (last 3 years)
* Monthly Enrollment (last 3 years)
* Type of work
* Summaries of Benefit Coverages (SBC)
* Existing Plan Costs and Renewal
* Medical and Rx Plan group is interested in (Up to two plans are permitted)
* For any large claims over $350,000
  + Confirm if person(s) still actively working
  + If person(s) have terminated employment, provide termination date
* Provide plan changes during the last 3 years (if any)

**Please read the following participation requirements:**

* To ensure a timely enrollment, the Fund requires **a minimum 30-day** implementation period. However, we will work with you to accommodate a shorter time frame when necessary, but it may impact how quickly eligibility can be established with Fund vendors.
* Coverage always starts the first of the month.

BTF Must be the only benefit option made available to the group.

* At least 75% participation of the group is required, **except those who waive because they have other coverage (i.e., spouse, Tricare, etc.**).
* Non-Bargaining employees can participate. Up to 1/3 of the group can be Non-Bargaining employees.
* Other unions can participate as long as IAM Union members participate.
* Short Term Disability and Life and Accidental Death and Dismemberment (AD&D) Coverages are available when the employer participates in one of our Medical, Dental, or Vision Plans.
* A **signed Participation Agreement** **(PA)** is required before the Effective Date of Coverage (No exceptions).
* A copy of the current Collective Bargaining Agreement (CBA) in effect must be provided (may not reference the BTF as the Union’s Plan or the Union being responsible for the Plan).
* Employer point of contact information is required.
* Provide census list with employee names and column with bargaining/non-bargaining.
* \*\*For the Life AD&D quote: provide the desired level of coverage and a census list of all employees’ gender and date of birth (or age). Once this information is received, we will work with our Fund vendor to obtain Life AD&D rates.

**Example:** Flat amount of coverage $30,000:

|  |  |
| --- | --- |
| **Gender** | **DOB** |
| Male | 5/14/98 |
| Female | 2/20/88 |
| Male | 6/14/85 |
| Male | 4/12/76 |

For any questions, please contact the Education Department at (800) 457-3481.

BTF PROPOSAL REQUEST FORM

(400 Employees or more)

Please complete the Proposal Request in its entirety

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Territory:** | Click or tap here to enter text. | | | | | **Date:** | | | | Click or tap here to enter text. | | |
| **Union Lodge:** | Click or tap here to enter text. | | | | | | | | | | | |
| **Union Representative:** | Click or tap here to enter text. | | | | | | | | | | | |
| **Title:** | Click or tap here to enter text. | | | | | | | | | | | |
| **Address:** | Click or tap here to enter text. | | | | | | | | | | | |
| **City:** | Click or tap here to enter text. | | | | | | | | | | | |
| **State:** | Click or tap here to enter text. | | **Zip Code:** | | | | | | Click or tap here to enter text. | | | |
| **Phone:** | Click or tap here to enter text. | | | | **Fax:** | | | | Click or tap here to enter text. | | | |
| **Cell Phone:** | Click or tap here to enter text. | | | **E-Mail :** | | | | | Click or tap here to enter text. | | | |
| **EMPLOYER Name:** | Click or tap here to enter text. | | | | | | | | | | | |
| **Contact Name:** | Click or tap here to enter text. | | | | | | | | | | | |
| **Address:** | Click or tap here to enter text. | | | | | | | | | | | |
| **City:** | Click or tap here to enter text. | **State:** | | | | | Click or tap here to enter text. | | | | **Zip Code:** | Click or tap here to enter text. |
| **Phone:** | Click or tap here to enter text. | **Industry:** | | | | | | Click or tap here to enter text. | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Number of Location(s):** | Click or tap here to enter text. | **Work Location Zip Code(s):** | | Click or tap here to enter text. | **Work Location(s) City and State:** | | Click or tap here to enter text. |
| **# of CBA’s:** | Click or tap here to enter text. | **CBA Expiration Date(s):** | | **Click or tap here to enter text.** | **Date Proposal Needed By:** | | **Click or tap here to enter text.** |
| **Is this a govt contract?** | | **Yes No** | | **Are there subcontractors interested in participating?** | | **Yes\* No** | |
| **\*If yes, list subcontractor name(s):** | | | Click or tap here to enter text. | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **INTEREST:** | **Medical** | | | | | **Dental** | | | | | **Vision** | | **STD** | | | | | **Life AD & D\*\*** | |
| **At Least 75% of Group Must Be Covered, No more than 1/3 of Group can be Non-Bargaining Employees** | | | | | | | | | | | | | | | | | | | |
| **# Employees:** | **Bargaining:** | | | | Click or tap here to enter text. | | | **Non-Bargaining:** | | | | **Click or tap here to enter text.** | | | **Total:** | | Click or tap here to enter text. | | |
| **At Least 75% of Group to Be Covered?** | | **Yes No** | | | | | | | **Do Employees Contribute Toward Cost?** | | | | | | | **Yes No\*** | | | |
| \*(If no, employees are not allowed to waive coverage; If yes, note details in comments section below) | | | | | | | | | | | | | | | | | | | |
| **Interest in Retiree Plan?** | | | | Click or tap here to enter text. | | | **Explain:** | | | | Click or tap here to enter text. | | | | | | | | |
| **Any Employees on Short Term Disability?** | | | | | | | | | | Click or tap here to enter text. | | | | **COBRA?** | | | | | Click or tap here to enter text. |
| **Proposed Effective Date:** | | | *(Proposed Effective Date of Coverage is Always the 1st of the Month)* | | | | | | | | | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | | | | | | | | | |
| **Comments:** Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | |