

NATIONAL EMPLOYEES HEALTH PLAN

c/o Lou Csordas
United Benefit Advisors, LLC
PO Box 430
Sterling Heights, MI 48311

TRUST ACCEPTANCE

This Trust Acceptance is entered into by and between the Employer listed below and the Board of Trustees of the National Employees Health Plan.

All Employers who are party to or otherwise bound by a collective bargaining agreement acknowledge, accept and agree to be bound by the Agreement and Declaration of Trust of the National Employees Health Plan. All Employers acknowledge accept and appoint the current Employer Trustees to act on their behalf and to accept future Trustees who are appointed or elected in accordance with the Trust document. All Employers further acknowledge that they are bound by the terms, provisions and conditions of rules, regulations, resolutions and amendments pertaining to the Health Plan as promulgated by the Trustees in accordance with the Trust Agreement, whether currently existing or promulgated during the term of this agreement.

Unless otherwise stated in the collective bargaining agreement and approved by the Trustees, contributions are due at the Health Plan office on the first day of the month for which the coverage is in effect. An Employer shall be considered delinquent if contributions for the prior month are not paid in full within seven (7) days of the first day of the next month. The Employer agrees to accompany payment with a uniform reporting form which will set forth the name of each employee, the amount of the contributions paid on behalf of each employee and such other pertinent information as

may be required by the Trustees. New hires and terminations must be reported within seven (7) days.

Contributions payable to the Health Plan are to be based upon the hourly, weekly, or monthly rates as set forth below.

The entire bargaining unit group must participate in the Health Plan, unless otherwise provided for in the collective bargaining agreement including allowing employees to waive coverage. Employees are eligible for benefits as identified and set forth below.

The Employer may be granted authorization to pay contributions to the Health Plan on behalf of employees not covered under the terms of the collective bargaining agreement. In the event that such permission is granted by the Trustees, the Employer shall be required to sign such other documents as may be necessary with respect to the participation of non-bargaining unit employees. Non-bargaining unit employees shall not be permitted to participate unless specifically named in a Participation Agreement which has been accepted by the Trustees.

In the event that the Employer is delinquent in the payment of its contributions to the Health Plan, the Employer shall be responsible for payment of any and all costs of collection in addition to any delinquent contributions as more fully set forth in the Health Plan's written collection procedures, a copy of which has been furnished to the Employer.

The term of this Trust Acceptance shall be co-extensive with that of the collective bargaining agreement. Upon termination of the Employer's obligation to contribute under the collective bargaining agreement, this agreement shall automatically expire.

However, the provisions of this Trust Acceptance and other Health Plan documents relating to the collection of delinquent contributions shall remain in full force and effect.

The payment of contributions to this Health Plan on behalf of a particular bargaining unit employee does not make any such employee eligible for benefits unless the Employer is signatory to this Agreement and this Agreement has been approved by the Trustees.

Teamster Local Identifier _____

EMPLOYER

NATIONAL EMPLOYEES HEALTH PLAN

Name: _____

By: _____

Authorized Union Representative

By: _____

Date: _____

Title: _____

By: _____

Trustee

Date: _____

By: _____

Trustee

Date: _____

CONTRACT DATA

Proposal Number

Medical Plan PPO Suffix

Medical Plan HMO Suffix

Prescription Drug Copay

Vision

Dental

STD

Life

Retiree Coverage

Employee Waiting Period For NEHP Benefits _____

Employee Opt Out Provision Yes ___ No ___

If yes please provide a copy of the Opt Out Provision

Covered Employee Class: _____

Billing Mode: Hourly ___ Weekly ___ Monthly ___

Rates – See Addendum A