California Small Manufacturing

Health & Welfare Trust

Employer Group Application

Company Information

Company Name:		Plan Name:	
Address:	City:	State:	Zip:
Billing Address: (If Different from above)		Requested Start Date:	

Key Contacts:

Routine:	Phone:	Fax:	Email:
Billing:	Phone:	Fax:	Email:
Executive:	Phone:	Fax:	Email:

Agent/Broker Information

Agent/Broker Name:		Tax ID:	
Commissions Check Made Payable to:		License No:	Exp.:
Phone #:	Fax #:	Email:	
Address:	City:	State:	Zip:

Application is hereby made for membership in California Small Manufacturers Health & Welfare Trust (CSMHWT). This is an application only. Issuance of a Group Agreement is subject to receipt of first month's premium and to review and approval by CSM HWT.

All eligible employees and dependents will be offered this benefit package. If accepted, the employer agrees to make required payroll deductions for employees who enroll in this plan and to pay the required monthly premium and administration fee.

The Employer also agrees to notify all eligible employees of their ability to enroll in the plan after their waiting period.

Employer Signature _____ Title _____

Print Name _____ Date _____