

FRINGE BENEFITS

This document must be completed for each fringe benefit plan the employer participates in on behalf of their employees working on the below listed project.

EMPLOYER:
PLAN NAME: _____

TYPE OF PLAN: _____ Plan Account # _____

EFFECTIVE DATE of PLAN:
thru _____

(NAME, ADDRESS & PHONE # OF PLAN ADMINISTRATOR)

(NAME, ADDRESS & PHONE # OF PLAN TRUSTEE/CUSTODIAN)

EMPLOYEE NAME or TRADE CLASSIFICATION	EMPLOYERS CONTRIBUTION	FREQUENCY (HOUR,WEEK,MONTH)
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

Company Representative

Date: _____