	CONTRAC	TOR	FRI	NGE BENEFIT	STATEMENT	
Contract Name/ Number:				Project Location:	Today's Date:	
PWP #:				Contractor/Sub Contractor Name:		
Name of Awarding Body:				Signatory to Collective Bargaining Agreement: Yes No		
				If Yes: Local Name and Number:		
Name of Contact Person:						
Email Address:						
Tel. No: Fax No:				License No:	Tel. No:	
				Fax No: Email Address:		
					nen checking payrolls on the above con ir job classifications as set forth below	
Classification				Effective Date:	Group ID #(s):	
FRINGE BENEFITS	Health and Welfare	Paid To:	Fund,	Plan or Program Name:		
	\$	Address:_			Tel. No:	
	Pension					
	\$	Address:_			Tel. No:	
	Vacation/Holiday					
	\$	Address:_			Tel. No:	
	Training and/or Other					
	\$	Address:_			Tel. No:	
Classific				Effective Date:	Group ID #(s):	
FRINGE BENEFITS	Health and Welfare	Paid To:	Fund.	Plan or Program Name:		
	\$					
	Pension					
	\$		•		Tel. No:	
	Vacation/Holiday					
	\$			_	Tel. No:	
	Training and/or Other				TOR NO	
	\$	Address:	-		Tel. No:	
	signing below, I certify that	the Bona F	ide Frir	nge Benefits meet the requi	ork if a change in rate is made. rements of Assembly Bill 190 and that the	
<u>p</u>	payments are made to the ap	proved pla	ın, fund	(s), or program listed above	e. (Use additional sheets as necessary.)	

Printed Name/Title

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