

Employer Participation and Adoption Agreement

Automotive Aftermarket Association Southeast Health Fund

The participating employer named below (“Employer”) acknowledges that it is engaged in the automotive aftermarket industry and a member in good standing in the Automotive Aftermarket Association Southeast, Inc. (the “Association”). The Employer hereby adopts a Health/Dental Insurance Benefit program (the “Plan”), the terms of which are set forth in this adoption agreement in accordance with the Automotive Aftermarket Association Southeast Health Fund (the “Trust”). The Employer agrees to be bound by the terms and conditions of the Trust, as amended, reestablished, restated, or supplemented from time to time, which are hereby and incorporated herein by reference.

Name of Employer _____

Address of Employer _____

Effective Date of Adoption _____ Total number of Employees _____

- COMPETITOR HEALTH PLAN**

- VALUE HEALTH PLAN**

- ECONOMY HEALTH PLAN**

- DENTAL PLAN**

Eligible Employees:

All employees of the participating Employer will be eligible to participate in the Plan, except the following:

- ▶ Employees with less than 90 days of service.
Number of employees currently under this exclusion: _____
- ▶ Part-time (regularly work less than 30 hours per week) or seasonal (normally work less than 6 months during any year) employees.
Number of employees currently under this exclusion: _____
- ▶ Employees covered under a collective bargaining agreement under which benefits were the subject of bargaining.
Number of employees currently under this exclusion: _____
- ▶ Non-resident aliens with no U S source income from the Employer.
Number of employees currently under this exclusion: _____
- ▶ Excluded from coverage for other reason. Please specify each reason and the respective number of employees currently excluded for each reason specified:
Example: Covered under spouse’s contract, Medicare, etc.
Reason _____ No. _____
Reason _____ No. _____

COMPUTATION OF ELIGIBLE EMPLOYEES:

Total number of employees:	_____
Less employees excluded above:	(_____)
Eligible employees:	<u>_____</u>

Number of employees **participating** in health insurance program: _____

Allocation of Employer and Employee Contributions

The Employer’s share of the contribution to the trust for all eligible employees electing to participate in the program shall equal _____% of the designated cost under the plan for individual health coverage, _____% of the designated cost under the plan for family health coverage, and _____% of the designated cost under the plan for individual dental coverage, and _____% of the designated cost under the plan for family dental coverage.

The Employee’s share of the contribution to the trust shall equal _____% of the designated cost under the plan for individual health coverage, _____% of the designated cost under the plan for family health coverage, and _____% of the designated cost under the plan for individual dental coverage, and _____% of the designated cost under the plan for family dental coverage.

If there is any distinction in the allocation of Employer and Employee contributions among eligible employees electing to participate in the program, please explain the distinction in detail on the back of this page of this agreement.

Contributions made to the Trust shall be available to pay benefits to all eligible and participating employees of all Employers electing by agreement to participate in the Trust. The designated cost under the Trust for available coverage shall be subject to change from time to time determined by the Board of Trustees thereof. The Employer hereby designates the Association as its agent for all Trust purposes. The Association with the consent of the Board of Trustees of the Trust, reserves the right from time to time to amend the terms and provisions of the Trust, to change the coverage options and costs available under the Trust, and to terminate the Trust. The employer shall be permitted to discontinue or revoke its participation in the Trust by 30 days written notice to the Board of Trustees of the Trust. The Employer is required to continuously meet the Trust minimum participation requirements.

In no event shall any portion of the corpus or income of the Trust be used for or diverted for purposes other than providing health, dental, and life insurance benefits to employees of the Employer or other participating employers from time to time participating in the Trust. The Board of Trustees of the trust shall have the authority to make any and all necessary rules or regulations, binding on the Employers and Employees, to effectuate the purpose of the Trust.

The Employer hereby acknowledges that it is liable for continued contributions to the Trust for so long as this document remains in effect. The Employer understands that the Board of Trustees of the Trust will take all necessary actions under ERISA to procure payment to the Trust of monies due from the Employer. In the event the Employer is delinquent in contributions to the Trust, ERISA provides that the Trust is entitled to recover from the Employer (i) delinquent contributions; (ii) interest on the delinquent contributions; (iii) the greater of interest on the contributions or liquidated damages specified in the Plan; (iv) costs of the collections procedures, including reasonable attorney's fees; and (v) any other equitable or legal relief a court deems appropriate. In the event of any such delinquency, the Board of Trustees of the trust will also notify the employees of the Employer who are participating in the Plan of the termination of their coverage due to the Employer's delinquency in payment. In any event, claims will be honored to the paid to date.

IN WITNESS WHEREOF, the Employer has caused this document to be executed on this _____ day of _____, 20_____, and the Employer acknowledges that all actions necessary to authorize the execution hereof by the undersigned officers of the Employer have been taken.

Employer: _____

Signed: _____ Title: _____

Attest or Witness: _____

Accepted on behalf of the TRUST on this _____ day of _____, 20_____, by _____, Administrator. Randal H. Ward, CAE
--