ABC Northern California Chapter

# HEALTH BENEFIT TRUST

Monthly Transmittal

| | | |
|---|---|---|
| **Employer:** | | **Month Work:** |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Date:** | | |
| **Starting with** | **day of** | |
| **Inclusive to** | **day of** | |

**For ALL ABC NorCal Apprentices** hourly benefit contribution rate is **$6.50**

| APPRENTICE NAME | LAST4 DIGITS OF SS # | HOURS WORKED | HEALTH CONTRIBUTION RATE | TOTAL |
|---|---|---|---|---|
| | | | **$ 6.50** | $ 0.00 |
| | | | $ 6.50 | $ 0.00 |
| | | | $ 6.50 | $ 0.00 |
| | | | $ 6.50 | $ 0.00 |
| | | | $ 6.50 | $ 0.00 |
| | | | $ 6.50 | $ 0.00 |
| | | | $ 6.50 | $ 0.00 |
| | | | $ 6.50 | $ 0.00 |
| | | | $ 6.50 | $ 0.00 |
| | | | $ 6.50 | $ 0.00 |

Subtotal: $ 0.00

10% Penalty Assessment (if required) _____

Use additional sheets as needed.
Please enter zero (0) if no hours were worked.

**TOTAL AMOUNT ENCLOSED** $ 0.00

NOTE: Contributions are due and payable the 10th of the month following hours worked. 10% penalty assessed to subscribing contractors if received after the 15th of the month.

*I certify that all employees required to be reported by the Adoption Agreement between the employer and **ABC NorCal Benefit Trust Fund** and all hours paid are fully and accurately set forth.*

Signature:_____Date: _____

Make check payable to:
Mail payments and worksheet to:

ABC NorCal Benefit Trust
Polycomp Administrative Services, Inc.
404 Camino Del Rio S, Ste 608
San Diego, CA 92108

If you have any questions please call Frances Ruelas at (925)-960-8507

Updated 10/03/16