Catholic Benefits ASSOCIATION
THE POWER OF ASSOCIATION™

PRIVATE EMPLOYER MEMBERSHIP APPLICATION

Name of Organization: _____

Address: _____

_____

Name of Representative: _____

Position: _____

Phone: _____

Email: _____

The organization hereby applies, for itself, its affiliates and its subsidiaries as listed on Schedule A (if applicable), for membership in Catholic Benefits Association.

The organization hereby represents, for itself and its related employers, that (please initial **EACH**):

_____ Catholics (or trusts or other entities wholly controlled by Catholics) own 51% or more of the employer;

_____ 51% or more of the employers' governing bodies, if any, are Catholic; and,

_____ Either their respective owners or their respective governing bodies are committed to provide health care benefits to their employees or contractors that are consistent with Catholic values.

_____ The organization understands that should the three qualifications for membership, initialed above, change *in any way*, it is the responsibility of the organization to notify Catholic Benefits Association immediately to determine continued qualification for membership.

Catholic Benefits ASSOCIATION
THE POWER OF ASSOCIATION™

As a condition for membership in the Association, the organization agrees to pay dues and assessments to the Association based on the number of employees enrolled on the employer-sponsored health plan. Dues to be paid, as determined by the Association's Board of Directors, and which, as of the date of this application, are:

NUMBER OF EMPLOYEES	1 – 14 EEs	15 or more EEs
MEMBERSHIP DUES	$300/year	$1.50/month/employee, Capped at $4000/month

If the organization does not offer a health plan or is a sole proprietor, the minimum amount will apply.

The organization hereby represents (i) that it has the authority to apply for membership in the Association for itself and its related employers, and (ii) that its related employers which it intends to be included as members of the Association are identified on Schedule A,

The total number of covered employees[1] for the organization and the related employers

is_____.

_____ _____

(Name of Organization) (Date)

_____ _____

(Representative Signature) (Position)

[1] *A "covered employee" is an employee participating in a health plan sponsored or maintained by the applicant organization or a health plan sponsored or maintained by any related employer. This number is updated annually or with significant changes reported by employer.*

Catholic Benefits ASSOCIATION

THE POWER OF ASSOCIATION™

Schedule A

RELATED EMPLOYERS TO BE ADMITTED AS MEMBERS [2]

The applicant organization identifies the following separately incorporated related employers (other than parishes, which need not be separately identified) and acknowledges that pursuant to this Application for Membership, each of them will be admitted as a member of The Catholic Benefits Association:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

---

[2] Regardless of whether they are separately incorporated, parishes of an applicant will be members of the Association, and need not be listed on this Schedule A. If a diocese or archdiocese seeks to exclude a parish as a member of the Association, it may provide the Association written direction to that effect.

In the case of a diocese, archdiocese or eparchy, related employers include separately incorporated ministries, such as, by way of example, Catholic Charities, other Catholic relief organizations, schools, elder care facilities, cemetery associations, housing agencies and others.

In the case of other religious institute and non-diocesan non-profit entities, separately incorporated related employers should be identified.

If any related employer is a for profit entity, please write “for profit” behind the entity’s name.

Catholic Benefits ASSOCIATION
THE POWER OF ASSOCIATION™

NEW MEMBER BILLING PREFERENCES

New member dues are assessed after the first full month of membership. Membership dues are billed in arears for the preceding month and are sent on the first of each month. You can specify below the billing preference for your organization.

1. How often would you prefer to be billed? (Circle one):

   Monthly

   Annually (first billed will be prorated for the remaining months of the current year)

2. Who should we reference when sending your invoice:

   Name: _____

   Position: _____

   Email Address: _____

3. Our invoices are typically emailed; however, you can indicate if you would prefer mailed invoices instead (Check only as needed):

   ☐ Please email invoices to (if different from above):

   Name: _____

   Email Address: _____

   ☐ Please mail invoices to the attention of:

   Name: _____

RETURN COMPLETED APPLICATIONS: mandycox@catholicbenefitsassociation.org

OR 695 Jerry Street Suite 306 / Castle Rock / Colorado / 80104