

Michigan Conference of Teamsters Welfare Fund

Serving Teamster families since 1949

UNION TRUSTEES

Paul H. Harrison
Todd W. Lince
Kevin D. Moore
Gregory W. Nowak

2700 Trumbull Avenue, Detroit, Michigan 48216
(313) 964-2400
www.mct_wf.org

Executive Director
Kyle R. Stallman

EMPLOYER TRUSTEES

Raymond J. Buratto
Robert W. Jones
Ann R. Zick

NOTIFICATION OF CHANGE IN PARTICIPANT EMPLOYMENT STATUS

Employee's Name: _____ Social Security Number: _____ - _____ - _____

Complete the appropriate section as it pertains to the Participant's employment status notification and fill out the Employer information below.

Section 1 – CHANGE TO A NON-ACTIVE STATUS

Last Date Worked: _____ Date of Status Change: _____
(MM/DD/YY) (MM/DD/YY)

Contributions must be remitted pursuant to any contribution obligation provided for in the Participation Agreement and/or Collective Bargaining Agreement. Failure to timely notify MCTWF of employment status changes will obligate the Employer for contributions on behalf of the Participant through the date the status change is ultimately reported. **Please identify the participant's non-active status by checking the appropriate box below:**

- | | | |
|---|--|--|
| <input type="checkbox"/> Deceased / Date _____ | <input type="checkbox"/> Laid Off | <input type="checkbox"/> Quit |
| <input type="checkbox"/> Disabled – On-the-Job*
FMLA Yes / No (circle one) | <input type="checkbox"/> On Military Leave | <input type="checkbox"/> Reduced Hours (Explain below) |
| <input type="checkbox"/> Disabled – Off-the-Job
FMLA Yes / No (circle one) | <input type="checkbox"/> On Strike | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Fired | <input type="checkbox"/> Locked Out | <input type="checkbox"/> Suspended |
| <input type="checkbox"/> Due to Gross Misconduct | <input type="checkbox"/> On Personal Leave
FMLA Yes / No (circle one) | <input type="checkbox"/> Other (Explain below) |
| <input type="checkbox"/> Due to Other than Gross Misconduct | | |

Explanation: _____

*If status change is due to an on-the-job illness or injury, please provide a copy of the Employer's Report of Injury. The Submission of the report of injury must not delay the submission of the employment status change.

Section 2 – RESUMPTION OF ACTIVE STATUS

Participant has resumed active employment as of: _____
(MM/DD/YY)

Section 3 – NEW EMPLOYEE INFORMATION

Hire Date: _____ **Required Contribution Commencement Date: _____
(MM/DD/YY) (MM/DD/YY)

Participant Date of Birth: _____
(MM/DD/YY)

Participant Address: _____
(street address, city, state, zip)

MCTWF requires that contributions be made on behalf of an Employee commencing for the week in which falls the 91st day following the commencement of the individual's employment as an Employee. However, if the Employee is subject to a contractual probationary period, the 90 days is counted beginning upon the earlier of the completion of the contractual probationary period, or the completion of the following limits on such probationary period: (1) 210 calendar days for calendar day probationary periods; (2) 150 working days for working day probationary periods; (3) 1,200 working hours for working hour probationary periods; or (4) for probationary periods not based on calendar days, working days, or working hours, as determined by the MCTWF Trustees consistent with probationary periods stated above. **In order for coverage to commence, MCTWF must receive a fully completed Enrollment Card and all required supporting documentation.

Employer Name: _____ Company #: _____

Employer Representative Name: _____ Title: _____

Employer Representative Signature: _____ Date: _____
(MM/DD/YY)

Send this completed form to employmentstatuschange@mctwf.org or fax to 313-964-3144 (no cover sheet required). For inquiries, contact your Employer Account Representative at 313-964-2400.