EXHIBIT C

DISTRICT COUNCIL 16 NORTHERN CALIFORNIA
HEALTH AND WELFARE TRUST FUND

SUBSCRIBER AGREEMENT
FOR NON-BARGAINING EMPLOYEES OF SIGNATORY EMPLOYERS

Employee Attestation

ELIGIBILITY: I understand that I must be a non-bargained full-time employee of an employer with bargained employees under a collective bargaining agreement with District Council 16, International Union of Painters and Allied Trades, regularly scheduled to work at least 30 hours per week on average for the year. If I am a bargained employee, I understand that I am not eligible for coverage under the Subscriber Agreement.

CONTRIBUTION: I authorize my employer to deduct the requested contribution, if any, from my earnings.

BENEFIT AVAILABILITY: I understand that my benefits under this Plan begin with a specific effective date that will not begin until the 1st day of the month following two (2) consecutive months in which I am regularly scheduled to work at least 30 hours per week, provided that the Fund has received a full contribution on my behalf; and coverage shall terminate on the first day of the third month following the month for which the last contribution was made on my behalf by the employer. Furthermore, I understand that after the Employer's second calendar year of participation, coverage shall cease if the Employer does not, on a regular basis, hire one or more employees covered by a Collective Bargaining Agreement with the Union and has not paid contributions on behalf of at least one bargaining unit employee who has had at least 870 hours contributed on his behalf to one of the multi-employer pension plans affiliated with District Council 16 or IUPAT during the previous twelve (12) months, unless the exception for Working Employers applies. I acknowledge that if I attempt to utilize the benefit plan or prescription drug card when coverage is no longer effective under the Plan, I will be personally responsible for those expenses incurred and can be billed by providers or the Trust Fund for services rendered after the coverage termination date.

U.S. RESIDENT: I understand that coverage under this Plan is available to United States residents and benefits are not payable for medical expenses outside the United States, except when traveling.

COVERAGE CANNOT BE DECLINED: I understand that coverage for myself or my dependents cannot be declined except as provided under the Subscriber Agreement and Plan.

_____	_____
Signature of Employee	Date
_____	_____
Printed Name of Employee	Employer Name

<u>Note</u>: Employer is responsible for submitting a completed Exhibit C to the Fund Office on behalf of each Employee covered under the Subscriber Agreement.