AWC Employee Benefit Trust
Non-City Entity Application

wacities.org

Organization name: _____

Nonprofit: ☐ Yes ☐ No IRS classification: _____

Address: _____

Contact person: _____

Contact person email: _____ Contact person phone: _____

Sponsoring member city: _____

Number of benefit eligible employees: _____

1. Describe the function of your organization including who your organization serves and your customer base. Include any traditionally city-provided services and if helpful, you may attach a map of your service area.

2. How does your organization aid a member city or cities in fostering community partnerships, coalitions, and collaborations?

3. Does your organization have a formal agreement with an AWC member city or Trust participating city to provide services that are traditionally provided by a city or town (such as an Interlocal Agreement)? ☐ Yes ☐ No
   If yes, please attach a copy of this agreement to your application.

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4. Has the council of your sponsoring city passed a resolution requesting membership for your organization with the AWC Trust? If yes: ☐ Yes ☐ No

   Date resolution was passed: _____

   Please attach a copy of this resolution to your application.

5. List or attach the names of the members of your governing board. Please indicate any board members that are elected or appointed city officials.

   _____ _____

   _____ _____

   _____ _____

   _____ _____

   _____ _____

   _____ _____

6. Are you eligible for coverage through another professional service or other organization (i.e. counties, fire commissioners, etc.) for which you are affiliated, a member of, or eligible for membership due to the non-city entity's status or services it provides? ☐ Yes ☐ No

7. Does your organization currently have health benefits for employees? ☐ Yes ☐ No
   If yes, please complete the table below:

Type of benefit	Currently offered?	# of eligible employees	Current carrier/Plan administrator	How long with this provider?
Medical	☐ Yes ☐ No			
Dental	☐ Yes ☐ No			
Vision	☐ Yes ☐ No			
Life insurance	☐ Yes ☐ No			
Long-term disability	☐ Yes ☐ No			
Tax-favored accounts (HRA, FSA, HSA)	☐ Yes ☐ No			
Employee Assistance Program (EAP)	☐ Yes ☐ No			
Wellness Program	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

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8. Do you have any LEOFF I active employees or LEOFF I retirees? ☐ Yes ☐ No

   If yes, how many active LEOFF 1? _____

   If yes, how many retired LEOFF 1? _____

9. Do you have any employees who are currently on COBRA or are participating in your employer-sponsored retiree medical plan?

   COBRA ☐ Yes ☐ No If yes, how many? _____

   Retiree plan ☐ Yes ☐ No If yes, how many? _____

10. Does your organization anticipate a significant change in the number of benefit-eligible employees within the next 3–5 years? If yes, please explain.