# Ironworkers Collectively Bargained Workers' Compensation Program

**District Council of Iron Workers of the State of California and Vicinity**
**California Ironworkers Employers Council**

## Nevada Employer Acknowledgment of Participation

The undersigned employer,_____by signing this Employer Acknowledgment of Participation, hereby acknowledges and certifies that the undersigned employer has collectively bargained for and has agreed to be bound by all terms and conditions of the Ironworkers Workers' Compensation Addendum, attached hereto, entered into between the District Council Of Iron Workers Of The State Of California And Vicinity ("Union") and the Associations Comprising the California Ironworkers Employers Council, Inc.("Association"), pursuant to Nevada Revised Statutes 616A.466. The parties agree that injured employees whose claims are covered by this Addendum and who are receiving weekly temporary total disability benefits for such claims shall receive weekly temporary total disability benefits that are subject to a maximum weekly benefit that is one hundred ten percent (110%) of the maximum weekly benefit that is otherwise applicable under state law.

The undersigned employer also acknowledges and certifies that the undersigned employer has collectively bargained for and has agreed to be bound by all terms and conditions of the Agreement and Declaration of Trust Establishing the Ironworkers Workers' Compensation Trust ("Trust"), attached hereto. **This "Employer Acknowledgement of Participation" document must be executed by all parties at the time of coverage and participation in the Program and annually thereafter. The original copies must be forwarded to:**

Eric J Nobriga, Sr, Administrator
California Ironworkers ADR Program
2120 Foothill Blvd., Suite 100, La Verne, CA. 91750
Office: (626) 356-3051 Fax: (866) 322-2044
Email: eric.nobriga@ironworkerbenny.net

Employer Name: _____NV License #: _____

Employer Address: _____

Signed for the Employer By: _____ Date:_____

Print Name: _____

Insurance Company: _____ Policy #: _____

Signed for Insurance Carrier by: _____ Date:_____

Print Name: _____

Effective Date of Coverage: _____

Insurance Carrier hereby acknowledges the employer participation in the workers' compensation program and agrees to comply with all the requirements of the program.

Acknowledged by ICBWCP Administrator: _____
Date: _____