

FRINGE BENEFIT STATEMENT

Contract Number / Name:		Contract Location:		Date:	
Subcontractor Name:		Business Address:			
This form is to be submitted with the first certified payroll. In order that the proper Fringe Benefit rates can be verified when checking payrolls on the above contract, the hourly rates for fringe benefits, subsistence and/or travel allowance payment made for employees on the various classes of work are tabulated below.					
Classification:		Effective Date:		Subsistence or Travel Pay: \$	
FRINGE BENEFITS	Health & Welfare \$	Paid To: Name: _____ Address: _____			
	Pension \$	Paid To: Name: _____ Address: _____			
	Vacation/Holiday \$	Paid To: Name: _____ Address: _____			
	Training \$	Paid To: Name: _____ Address: _____			
	Other \$	Paid To: Name: _____ Address: _____			
Classification:		Effective Date:		Subsistence or Travel Pay: \$	
FRINGE BENEFITS	Health & Welfare \$	Paid To: Name: _____ Address: _____			
	Pension \$	Paid To: Name: _____ Address: _____			
	Vacation/Holiday \$	Paid To: Name: _____ Address: _____			
	Training \$	Paid To: Name: _____ Address: _____			
	Other \$	Paid To: Name: _____ Address: _____			
Classification:		Effective Date:		Subsistence or Travel Pay: \$	
FRINGE BENEFITS	Health & Welfare \$	Paid To: Name: _____ Address: _____			
	Pension \$	Paid To: Name: _____ Address: _____			
	Vacation/Holiday \$	Paid To: Name: _____ Address: _____			
	Training \$	Paid To: Name: _____ Address: _____			
	Other \$	Paid To: Name: _____ Address: _____			
Supplemental statements must be submitted during the progress of work should a change in rate of any of the classifications be made. I CERTIFY THAT THE FRINGE BENEFIT PAYMENTS ARE MADE TO THE APPROVED PLANS, FUNDS OR PROGRAMS AS LISTED ABOVE.					
Submitted (Subcontractor)		By (Name and Title)		Signature	