



CDBG Grant No: _____
City Project No. _____
Project Name: _____
Pre-Conference Meeting: _____

LS-17 – CERTIFICATION FOR APPLICABLE FRINGE BENEFIT PAYMENTS**NAME OF CONTRACTOR/SUBCONTRACTOR:**

Provide the name, address, and telephone number of each Plan for fringe benefits provided. If plans differ between classifications, use separate forms and specify the classification.

1. Health and Welfare:
Address:
Plan #, Group #, etc.:
Phone/FAX Numbers:
Point of Contact:
2. Pension/401K:
Address:
Plan #, Group #, etc.:
Phone/FAX Numbers:
Point of Contact:
3. Dental, Vision, STD, LTD, Life Insurance, Hospital Indemnity, Accident Insurance, Critical Illness, Telemedicine, Legal, Identity Theft Protection:
Address:
Plan #, Group #, etc.:
Phone/FAX Numbers:
Point of Contact:
4. Health Equity:
Address:
Plan #, Group #, etc.:
Phone/FAX Numbers:
Point of Contact:
5. Other:

I hereby certify that I make payments to the fringe benefit plans, funds, or programs identified above.

Signature_____
Date