

CITY OF LOS ANGELES
 Department of Public Works
 Bureau of Contract Administration
 Office of Contract Compliance
 1149 S. Broadway, 3rd Floor, Los Angeles, CA 90015
 Phone: (213) 847-2625 - Fax: (213) 847-2777

EQUAL BENEFITS ORDINANCE COMPLIANCE FORM

Your company must be certified as complying with Los Angeles Administrative Code Section 10.8.2.1, Equal Benefits Ordinance, prior to the execution of a City agreement. This form must be returned to the City department awarding the agreement. If responding to a request for bid/proposal, submit this form with the bid/proposal.

City Dept. Awarding Contract: _____ **Contact/Phone:** _____

SECTION 1. CONTACT INFORMATION

Company Name: _____
 Company Address: _____
 City: _____ State: _____ Zip: _____
 Contact Person: _____ Phone: _____ Fax: _____

I am a one-person contractor, and I have no employees. Yes No (if you answered "Yes," go to Section 3)

Approximate Number of Employees in the United States: _____

Are any of your employees covered by a collective bargaining agreement or union trust fund? Yes No

SECTION 2. COMPLIANCE QUESTIONS

Has your company previously submitted a Compliance Form and all supporting documentation? Yes No
 If **Yes**, AND the benefits provided to your employees have not changed since that time, continue onto Section 3. If No, OR if the benefits provided to your employees have changed since that time, complete the rest of this form.

In the table below, check all benefits that your company currently provides to employees or to which your employees have access. Provide information for each benefits carrier if your employees have access to more than one carrier. Note: some benefits are available or apply to employees because they have a spouse or domestic partner to whom the benefit applies, such as bereavement leave that allows an employee time off because of the death of a spouse or domestic partner; other benefits are provided directly to the spouse or domestic partner, such as medical insurance that covers the spouse or domestic partner as a dependent.

	BENEFIT(S) YOUR COMPANY CURRENTLY OFFERS	This Benefit is Not Offered to Employees	This Benefit is Available to Employees	Available/Applies to Spouses of Employees	Available/Applies to Domestic Partners of Employees
1	Health Insurance (List Name of Carrier(s))				
	Health Carrier 1:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Health Carrier 2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> additional carriers on attachment.				
2	Dental Insurance (List Name of Carrier(s))				
	Dental Carrier 1:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dental Carrier 2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> additional carriers on attachment.				
3	Vision Plan (List Name of Carrier(s))				
	Vision Carrier 1:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Vision Carrier 2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Pension/401(k) Plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Bereavement Leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Family Leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Parental Leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Employee Assistance Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Relocation & Travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Company Discount, Facilities & Events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Credit Union	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Child Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YOU MUST SUBMIT SUPPORTING DOCUMENTATION TO VERIFY EACH BENEFIT MARKED. Without proper documentation for **each carrier and each benefit marked**, your company cannot be certified as complying with the EBO. If documentation for a particular benefit does not exist, attach an explanation. Refer to the "Documentation to Verify Compliance with the Equal Benefits Ordinance" fact sheet for more information on the type of documentation that must be submitted to verify compliance with the EBO.

If in the Table in Section 2 you indicated that your company does not provide all benefits equally throughout its entire operations to all your employees with spouses and employees with domestic partners of the same and different sex, you may:

- a. Request additional time to comply with the EBO.** Provisional Compliance may be granted to Contractors who agree to fully comply with the EBO but need more time to incorporate the requirements of the EBO into their operations. Submit the Application for Provisional Compliance (OCC/EBO-3) and supporting documentation with this Compliance Form.
- b. Request to be allowed to comply with the EBO by providing affected employees with the cash equivalent.** Your company must agree to provide employees with a cash equivalent. In most cases, the cash equivalent is the amount of money equivalent to what your company pays for spousal benefits that are unavailable for domestic partners, or vice versa. Submit a completed Application for Reasonable Measures Determination (OCC/EBO-2) and supporting documentation with this Compliance Form.
- c. Comply on a Contract-by-Contract Basis.** Compliance may be granted on a contract-by-contract basis for those Contractors who have multiple locations in the U.S. but cannot comply with the EBO throughout the Contractor's operations. Indicate below the compliance category you are requesting:
 - Contractor has multiple operations located both within and outside City limits. Contractor will comply with the EBO only for the operation(s) located within City limits and for employee(s) located elsewhere in the United States who perform work relating to the City agreement. Supporting documentation for the affected operation(s)/employees must be submitted.
 - Contractor has no offices within City limits but does have (an) employee(s) working on the City agreement located elsewhere in the United States. Contractor will comply with the EBO only for employee(s) located elsewhere in the United States who perform work relating to the City agreement. Supporting documentation for the affected employee(s) must be submitted.

SECTION 3. EXECUTE THE DECLARATION AND SUBMIT THE FORM TO THE AWARDING DEPARTMENT

This form must be returned to the City department awarding the agreement. If responding to a request for bid/proposal, submit this form with the bid/proposal to the awarding department. The awarding department will forward the form to the Department of Public Works, Bureau of Contract Administration, Office of Contract Compliance for review.

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that I am authorized to bind this entity contractually.

Executed this _____ day of _____, in the year _____, at _____, _____
(City) (State)

Signature

Mailing Address

Name of Signatory (please print)

City, State, Zip Code

Title

EIN/TIN

CITY OF LOS ANGELES

Department of Public Works
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DOCUMENTATION TO VERIFY COMPLIANCE WITH THE EQUAL BENEFITS ORDINANCE

Section 2 of the Equal Benefits Ordinance Compliance Form (Form OCC/EBO-1) requires that you submit supporting documentation to the Office of Contract Compliance to verify that all benefits marked in your response(s) are offered in a nondiscriminatory manner. This list is intended to be used only as a guide for the type of documentation needed.

Health, Dental, Vision Insurance: A statement from your insurance provider that spouses and domestic partners receive equal coverage in your medical plan. This may be in a letter from your insurance provider or reflected in the eligibility section of your official insurance plan document. Note that "domestic partner" includes same-sex as well as different-sex partners so that the definition of "domestic partner" contained in the plan document must include different-sex partners.

Pension/401(k) Plans: Documentation should indicate that participating employees may designate a beneficiary to receive the amount payable upon the death of the employee. Submit a blank beneficiary designation form.

Bereavement Leave: Your bereavement leave or funeral leave policy indicating the benefit is offered equally. If your policy allows employees time off from work because of the death of a spouse, it should also allow for time off because of the death of a domestic partner. If the policy allows time off for the death of a parent in-law or other relative of a spouse, it must include time off for the death of a domestic partner's equivalent relative.

Family Leave: Your company's Family and Medical Leave Act policy. All companies with 50 or more employees must offer this benefit. Your policy should indicate that employees may take leave because of the serious medical condition of their spouse or domestic partner.

Parental Leave: Your company's policy indicating that employees may take leave for the birth or adoption of a child. If leave is available for step-children (the spouse's child) then leave should also be made available for the child of a domestic partner.

Employee Assistance Program (EAP): The benefit typically refers to programs that allow employees and their family members access to counselors who provide short-term counseling and referrals to assist in dealing with issues such as family problems, addiction, and financial and legal difficulties. Your company's EAP policy must confirm that spouses, domestic partners and their parents and children are equally eligible (or ineligible) for such benefits. If provided through a third party, a statement from the third party provider regarding eligibility is required.

Relocation & Travel: Your company's policy confirming that expenses for travel or relocation will be paid on the same basis for spouses and domestic partners of employees.

Company Discounts, Facilities & Events: Your company's policy confirming that to the extent discounts, facilities (such as a gym) and events (such as a company holiday party) are equally available to spouses and domestic partners of employees.

Credit Union: Documentation from the credit union indicating that spouses and domestic partners have equal access to credit union services.

Child Care: Documentation that the children of spouses (step-children) and children of domestic partners have equal access to child care services.

Other Benefits: Documentation of any other benefits listed to indicate that they are offered equally.