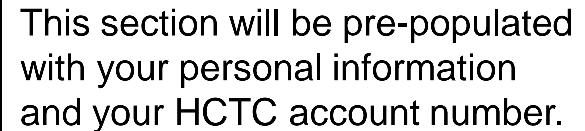
Instructions for completing and returning the Voluntary Employee Beneficiary Association (VEBA) Attestation Form – <u>Return no later than January 7th, 2011</u>

Voluntary Employee Beneficiary Association (VEBA) Attestation

<FIRST NAME><LAST NAME>
<ADDRESS LINE 1>
<ADDRESS LINE 2>
<ADDRESS LINE 3>
<CITY>,<STATE><POSTAL CODE>

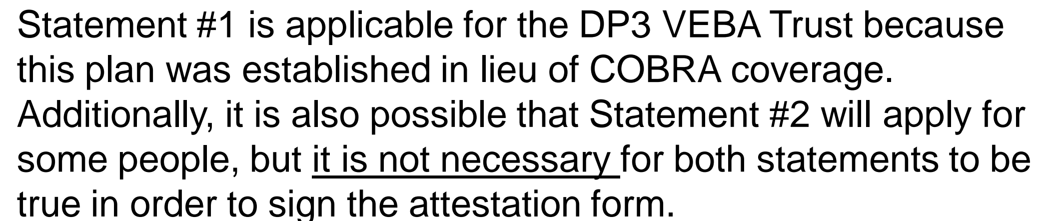
<ACCOUNT NUMBER>



Instructions: By completing this attestation, you confirm that you have a qualified health plan for the HCTC. Please sign and date this attestation if one of the following statements applies to you.

1. I chose a health plan through a VEBA that was established as a result of my former employer's bankruptcy, in lieu of COBRA coverage and retiree benefits; OR

2. I have lifetime COBRA coverage, and I am not enrolled in a health plan offered through a VEBA.



Sign and Date This Section

Under penalty of perjury, I certify that one of the statements listed above applies to me and my family members, and I declare that the information I am certifying is true, complete, and accurate, to the best of my knowledge. I understand that a knowingly willfully false statement on this form can result in my disqualification from the monthly HCTC program.

Signature

XXX-XX-1234

Today's Date

Last 4 digits of Social Security Number

Sign the date the form here as instructed.

Make sure to write in the last four digits of your Social Security Number. The numbers "1234" have been shown here as an example and as a reminder to write in the required information.