


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

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>

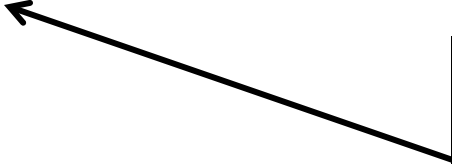
This section will be pre-populated with your personal information and your HCTC account number.



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.

Statement #1 is applicable for the DP3 VEBA Trust because this plan was established in lieu of COBRA coverage. Additionally, it is also possible that Statement #2 will apply for some people, but it is not necessary for both statements to be true in order to sign the attestation form.



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.

[Redacted Signature Area]

Signature

[Redacted Date Area]

Today's Date

XXX-XX-1234

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.