

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

Today’s Date XXX-XX-
Last 4 digits of Social Security Number