USW HRA FUND
GROUP HEALTH PLAN ATTESTATION FORM

PLEASE RETURN TO THE FUND OFFICE WITHIN 30 DAYS

Under the Affordable Care Act ("ACA"), the USW HRA Fund ("Fund") must confirm that all participants for whom employer contributions are being made to the Fund are enrolled in a group health plan that meets certain standards under the ACA. The Fund also must confirm that dependents covered by the HRA are enrolled in group health plan coverage that meets certain standards.

If you receive group health plan coverage through your employer, your employer should have provided you with a Summary of Benefits and Coverage that includes a statement of whether the plan meets the minimum value standard under the ACA. If you receive group health plan coverage through your spouse's employer or another source, the plan sponsor of that health plan should have provided you with this information. If you do not know whether the group health plan coverage in which you are enrolled meets the minimum value standard under the ACA, please contact that plan for more information. If you are not enrolled in group health plan coverage at all, please indicate that as well. You also must indicate whether your dependents are enrolled in group health plan coverage that meets the minimum value standard. **Please complete page 2 for your dependents.**

Name: _____

Address: _____

Telephone: _____Email:_____

Date of Birth: _____Employer: _____

Please select the statement below that applies to you:

_____ 1. I am enrolled in a group health plan provided by my employer.
_____ 2. I am enrolled in a group health plan that is not provided by my employer.
_____ 3. I am not enrolled in any other group health plan except the USW HRA Fund.

If you selected 1 or 2, please select the statement below that applies to you:

_____ A. The group health plan I am enrolled in meets the minimum value standard.
_____ B. The group health plan I am enrolled in does <u>not</u> meet the minimum value standard.

<u>If you selected A</u>, please sign the Attestation below:

I have read the statements above and attest that:

- As of today, I am enrolled in a group health plan that meets the minimum value standard of the Affordable Care Act.
- I understand that I must promptly inform the Fund if and when I am no longer enrolled in a group health plan that meets the minimum value standard under the Affordable Care Act.

Participant Signature: _____Date: _____

<u>If you selected B</u>, please provide the date that your coverage began under the health plan that does not meet the minimum value standard and sign below.

I am a participant in the USW HRA Fund. I am enrolled in a health plan that does <u>not</u> meet the minimum value standard under the Affordable Care Act beginning _____ (date).

Participant Signature: _____Date: _____

Your Name: ____

<u>Dependents – Complete for Each Dependent Enrolled in the HRA</u> (please use additional sheets, if needed)

Name of Dependent:____

Please select the statement below that applies to this dependent:

_____ 1. My dependent is enrolled in a group health plan provided by my employer.
_____ 2. My dependent is enrolled in a group health plan that is not provided by my employer.
_____ 3. My dependent is not enrolled in any other group health plan except the USW HRA Fund.

<u>If you selected 1 or 2</u>, please select the statement below that applies to this dependent:

_____ A. The group health plan my dependent is enrolled in meets the minimum value standard.
_____ B. The group health plan my dependent is enrolled in does <u>not</u> meet the minimum value standard.

* * * * *

Name of Dependent:____

Please select the statement below that applies to this dependent:

_____ 1. My dependent is enrolled in a group health plan provided by my employer.
_____ 2. My dependent is enrolled in a group health plan that is not provided by my employer.
_____ 3. My dependent is not enrolled in any other group health plan except the USW HRA Fund.

<u>If you selected 1 or 2</u>, please select the statement below that applies to this dependent:

_____ A. The group health plan my dependent is enrolled in meets the minimum value standard.
_____ B. The group health plan my dependent is enrolled in does <u>not</u> meet the minimum value standard.

* * * * *

Name of Dependent:____

Please select the statement below that applies to this dependent:

_____ 1. My dependent is enrolled in a group health plan provided by my employer.
_____ 2. My dependent is enrolled in a group health plan that is not provided by my employer.
_____ 3. My dependent is not enrolled in any other group health plan except the USW HRA Fund.

<u>If you selected 1 or 2</u>, please select the statement below that applies to this dependent:

_____ A. The group health plan my dependent is enrolled in meets the minimum value standard.
_____ B. The group health plan my dependent is enrolled in does <u>not</u> meet the minimum value standard.

* * * * *

Please contact the Fund Office at 1-800-251-4107, option 5 with any questions.

PLEASE RETURN THIS FORM TO THE FUND OFFICE

Mail to: USW HRA Fund
1101 Kermit Dr, Suite 800
Nashville, TN 37217

Fax To: 615-333-5797

Email to: hra@uswbenefitfunds.com

Revised December 2016