USW HRA FUND
GROUP HEALTH PLAN ATTESTATION FORM

2023

PLEASE RETURN TO THE FUND OFFICE WITHIN 30 DAYS

Under the Affordable Care Act ("ACA"), in order to receive benefits from the USW HRA Fund (the "Fund"), you must confirm that you and your Dependents are enrolled in a group health plan that meets the ACA's minimum value standards. If you have group health plan coverage, you should have received a Summary of Benefits and Coverage ("SBC") that indicates whether the plan meets the minimum value standards. If you do not have an SBC, ask your plan for one.

If you do not return this form within 30 days, the Fund will suspend your account until you return the form attesting to your enrollment in a group health plan that meets the ACA's minimum value standards.

Participant Name: _____

Last four of the SSN: XXX-XX- _____

Please put a check next to statement A or B (as applicable) below and sign:

_____A. I and my Dependents listed below ARE enrolled in a group health plan that meets the ACA's minimum value standards. I understand that I must promptly inform the Fund if and when I, or any of the Dependents listed below, are no longer enrolled in a group health plan that meets the ACA's minimum value standards.

_____B. I and my Dependents listed below are NOT enrolled in group health plan that meets the ACA's minimum value standards.

Participant Signature:_____Date: _____

List the names and birthdates of any Dependents (including your spouse) covered by the Fund below:

Name of Dependent_____ Date of Birth_____

Name of Dependent_____ Date of Birth_____

Name of Dependent_____ Date of Birth_____

Name of Dependent_____ Date of Birth_____

Name of Dependent_____ Date of Birth_____

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Please contact the Fund Office at 1-800-251-4107, option 2 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 July 2023