USW HRA FUND

MAJOR MEDICAL COVERAGE ATTESTATION FORM

PLEASE RETURN TO THE FUND OFFICE BY JANUARY 1, 2014

Due to new restrictions on Health Reimbursement Arrangements ("HRAs") imposed by the Patient Protection and Affordable Care Act ("PPACA"), the USW HRA Fund ("Fund") must confirm that all participants for whom employer contributions are being made to the Fund on their behalf are enrolled in major medical coverage that meets certain standards under PPACA.

If you receive major medical coverage through your employer, your employer should have provided you with both a notice and a Summary of Benefits and Coverage that contain an explanation as to whether that coverage meets the minimum value standard under PPACA. If you receive major medical 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 primary health plan in which you are enrolled meets the minimum value standard under PPACA, please contact that plan for more information. If you are not enrolled in major medical coverage at all, please indicate that as well.

Name: ____

Address: ____

Telephone: ______________________________________

Email: ______________________________________

Date of Birth: _____________________________________

Employer: ______________________________________

Please select the statement below that applies to you:

_____ 1. I am enrolled in a health plan provided by my employer.

_____ 2. I am enrolled in a health plan that is not provided by my employer.

_____ 3. I am not enrolled in any other health plan except the USW HRA Fund.

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

_____ A. The health plan I am enrolled in meets the minimum value standard.

_____ B. The health plan I am enrolled in does not meet the minimum value standard.

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If you selected A, please sign the Attestation below:

I have read the statements above and I attest to the following:

- As of January 1, 2014, I am enrolled in a group health plan that meets the minimum value standard of the Patient Protection and 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 of the Patient Protection and Affordable Care Act.

Participant Signature: ____

Date: ________________________________

If you selected B, please provide the date that you began being enrolled in 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 not meet the minimum value standard from the date ______________________.

Participant Signature: ____

Date: ________________________________

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

PLEASE RETURN THIS FORM TO THE FUND OFFICE USING ONE OF THE METHODS LISTED BELOW:

Mail to: USW HRA Fund
3320 Perimeter Hill Drive
Nashville, TN 37211

Fax To: 615-333-5797

Email to: hra@uswbenefitfunds.com