North Atlantic States Carpenters
Health Benefits Fund

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MEDICAL COVERAGE ATTESTATION FORM

As a result of changes to the law that affect Health Reimbursement Arrangements ("HRA") the North Atlantic Carpenters Health Benefits Fund ("Fund") and because you are not covered by the North Atlantic Carpenters Health Benefits Fund, must confirm you are enrolled in another group health plan that meets the minimum value of the Affordable Care Act ("ACA") in order for any employer contributions made on your behalf to be credited to the HRA.

If you receive medical coverage through your current employer or through your spouse's employer, you or your spouse should have received a Summary of Benefits and Coverage that contain an explanation as to whether your coverage meets the minimum value standard under ACA. If you do not know whether the primary health plan in which you are enrolled meets the minimum value standard under ACA, please contact that plan for more information.

Name: _____ SSN#: _____

Address: _____ Date of Birth: _____

Telephone: _____ E-mail: _____

Please select the statement below that applies to you, complete the required information and submit a copy of your insurance cards.

_____ 1. I am enrolled in **a Group Health Plan** provided by my employer. **Name of Employer**: _____
- Name of Insurance Company: _____Effective Date of Policy:_____
- Please indicate _____Single or _____ Family
- Please indicate Type of Coverage below:
- Medical_____ Vision _____ Dental _____ Prescriptions_____

_____ 2. I am enrolled in **a Group Health Plan** that is provided by my spouse's employer.

Name of Employer: _____ Please indicate who the primary insured is _____

- Name of Insurance Company: _____ Effective Date of Policy: _____
- Please indicate _____Single or _____ Family
- Please check Type of Coverage below:
- Medical_____ Vision _____ Dental _____ Prescriptions_____

_____ 3. I am enrolled only in **Medicaid or a State Marketplace Health Plan**. Please indicate who the primary insured is _____

- Name of Insurance Company: _____ Effective Date of Policy: _____
- Please indicate _____Single or _____ Family
- Please indicate Type of Coverage below:
- Medical_____ Vision _____ Dental _____ Prescriptions_____

_____ 4. I am enrolled in **Medicare**. Please indicate who the primary insured is _____

- Name of Insurance Company: _____ Effective Date of Policy:_____
- Please indicate _____Single or _____ Family
- Please indicate Type of Coverage below:
- Medical_____ Vision _____ Dental _____ Prescriptions_____

_____ 5. I am not enrolled in any health plan

OVER

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.

If you selected A, please sign the Attestation below:

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

- As of the date indicated below, I am enrolled in a group health plan that meets the minimum value standard of the Affordable Care Act.
- I understand that I must notify the Fund immediately if and when I am no longer enrolled in a group health plan that meets the minimum value standard of the ACA.
- I agree to indemnify the Fund and its Trustees from any losses caused by any misstatements made herein.

Participant Signature: _____

Date: _____

Please contact the Fund Office with any questions.

PLEASE RETURN TO THE FUND OFFICE WITHIN 30 DAYS