You are receiving this letter because you recently indicated that you wish to elect coverage for a family member. As part of our ongoing efforts to limit health care cost increases, we require anyone requesting coverage for family members to verify the coverage eligibility of those dependents.

This request to verify the eligibility of your dependent(s) is mandatory. You must take action immediately to ensure coverage for your dependent(s).

You must provide us with any verification requirements requested for your dependent(s) no later than the 22nd of the month in which your enrollment is effective. We encourage you to respond as soon as possible so you have sufficient time to provide any additional information that may be required to complete your enrollment request. If you do not reply, your dependent remains unverified. We will assume a non-response means you cannot verify the eligibility of your enrolled dependent and we will remove them from coverage, as of the last day of the month in which your enrollment was effective.

The deadline to complete the eligibility verification of your dependent(s) is the 22nd of the month in which your enrollment is effective. If you do not verify the eligibility of your dependent(s) by that date, all coverage for the unverified dependent(s) will be cancelled on the last day of the month in which your enrollment was effective.

To satisfy the requirements of this dependent eligibility audit:

- Complete the enclosed verification form to identify the dependent relationship, answer all questions, then sign, date, and mail the information to The Hilb Group, 2000 Chapel View Boulevard, Suite 240, Cranston, RI 02920, or upload the documents to the secure site, or return it to your Facility HR Coordinator.

If you do not have a required certificate or document copy, please order it immediately. The vital statistics website (http://www.cdc.gov/nchs/w2w.htm) can help you determine the process for obtaining document copies. You may be required to contact the County Clerk's office directly and there may be non-reimbursable costs associated with obtaining new copies.

If you have questions about this process, please contact your facility HR representative or the Benefits Help Line at (800) 201-7898.

Sincerely,

National Health Care, Inc. & Affiliates – VEBA Plan

NATIONAL HEALTH CARE, INC. & AFFILIATES – VEBA PLAN
DEPENDENT VERIFICATION FORM

RETURN ALL DOCUMENTS VIA ONE OF THE OPTIONS AVAILABLE BELOW

CERTIFICATION: I certify that the information I am providing is true and complete. I understand that if I knowingly provide false and/or misleading information or documentation, my employer may take appropriate disciplinary action.

Employee Name: _____

Employee Signature:_____Date _____

FAILURE TO COMPLETE THIS FORM AND RETURN THE REQUIRED DOCUMENTATION WILL RESULT IN CANCELLATION OF BENEFITS FOR AN UNVERIFIED DEPENDENT.

Check the appropriate box(es) below, attach the required documentation, and sign and date the form.

If you wish to elect coverage for a LEGAL SPOUSE:

○ This is my legal spouse. We are not divorced or annulled. I am attaching a copy of my marriage certificate.

If you wish to elect coverage for a DEPENDENT UNDER AGE 26:
Check a box that identifies your current relationship to this dependent and return required documentation.

○ This is my natural or adopted child. I am attaching a copy of their birth certificate or court document.

○ This is my stepchild. I am attaching a copy of a birth certificate or court document.

○ I and/or my spouse serve as legal guardian to this child. I am attaching a copy of the legal guardianship agreement.

If you wish to elect coverage for a <u>disabled</u> DEPENDENT OVER AGE 26:
Check a box that identifies your current relationship to this dependent and return required documentation*.

○ This is my natural or adopted child. I am attaching a copy of their birth certificate or court document.

○ This is my stepchild. I am attaching a copy of a birth certificate or court document.

○ I and/or my spouse serve as legal guardian to this child. I am attaching a copy of the legal guardianship agreement.

Circle an answer to each question:

Yes No Is this dependent married? If yes, on what date:_____/____/_____
Yes No Is this dependent incapable of self-sustaining employment?

*In addition to documentation to establish relationship (listed above), the dependent must meet the insurance carrier's criteria. Please contact your Human Resources department for additional medical/physician forms that must be completed.

REQUIRED DOCUMENTS NEEDED TO VERIFY ELIGIBILITY OF DEPENDENTS

Do not send original documents. Please send photocopies only as originals will not be returned.
PLEASE REMOVE/BLACK OUT SOCIAL SECURITY NUMBERS ON ALL DOCUMENTS

Legal Spouse	Return a photocopy of a marriage certificate or an acceptably executed marriage license that identifies the couple, date of marriage, legal jurisdiction and has a signature or seal showing it has been properly recorded with the County and/or State. A church ceremony document will not be acceptable if it does not meet these requirements.
Natural Child **Stepchild** **Adopted Child**	Return a legible photocopy of an acceptable birth certificate or a hospital birth record that shows your name or the name of your enrolled spouse as the parent of the child and is signed by a hospital administrator or physician on staff. If you do not have the birth certificate, you may send a copy of the pages of any court document that shows the parents' and child's names, identifies the court, county or state, date of the action, and the filing record with a signature and/or a stamp by a member of the court. You may also send a paternity test. • If your spouse is not enrolled and his/her name is on the birth certificate and your name is not listed, you must also provide a copy of your marriage certificate.
Legal Guardianship	Please send a copy of the court assignment of guardianship that is signed and/or stamped by a member of the court.
Foster Child	Return a copy of the court document or agency assignment.

RETURN ALL DOCUMENTS via ONE of these options below:

OPTION # 1:

Documents can be mailed to:

Hilb Group
2000 Chapel View Blvd, Suite 240
Cranston, RI 02920

OPTION # 2:

Documents can be uploaded securely at:

(For National Health Care Assoc and Constellation Employees)– www.nathealthcarebenefits.com (For Preferred Therapy Employees) – www.preftherapybenefits.com
Click on "Submit Dependent Verification Documentation" on web portal home page.

OPTION # 3:

Documents can be given to your location's HR department