NATIONAL HEALTH CARE, INC. & AFFILIATES – VEBA PLAN

ANNUAL SPOUSAL CERTIFICATION

(Must be completed in order to continue spouse's health plan coverage)

Name of Employee:_____ Facility/Location: _____

Employee Social Security Number:_____

Name of Spouse:_____

CERTIFICATION

- I certify that the above individual is currently my **legal spouse**, we are not divorced or annulled.
- I understand that if I become divorced or our marriage is annulled, I am required to notify the plan in writing within 60 days.
- I also understand that if I knowingly provide false and/or misleading information, documentation, or fail to timely notify the plan of a change in my marital status, my employer may take appropriate disciplinary action and require repayment for any claims incurred by the ineligible individual.

Employee's Signature: _____ Date _____

IN ORDER TO ENSURE THAT YOUR SPOUSE'S COVERAGE CONTINUES, YOU MUST RETURN THIS FORM USING ONE OF THE METHODS BELOW NO LATER THAN DECEMBER 15, 2021:	
Mail to:	The Hilb Group of New England, LLC 2000 Chapel View Drive, Suite 240 Cranston RI 02920
Upload Securely:	National Health Care Assoc & Constellation Employees: www.nathealthcarebenefits.com Preferred Therapy Employees: www.preftherapybenefits.com On the home page, click on the box that says "Submit Dependent Verification Documentation"
Employer:	Return to your location's Human Resources Representative

Failure to return this form by 12/15 will result in your spouse being cancelled from the plan effective 12/31/2021.