TIMBER PRODUCTS MANUFACTURERS TRUST

ELIGIBILITY VERIFICATION STATEMENT

Month: _____ Year: _____

THIS SIGNED VERIFICATION MUST ACCOMPANY
TPM HEALTH BENEFIT PLAN MONTHLY EMPLOYER CONTRIBUTION
TO MINIMIZE LOSS EXPOSURE AND POTENTIAL LEGAL LIABILITY
OF OUR MEMBER COMPANIES FOR INACCURATE REPORTING
OF EMPLOYEE ELIGIBILITY.

I have reviewed the billing statement for which payment is enclosed. **I certify** that the enclosed payment is only for those employees who are eligible for coverage. Eligibility is based upon an employee actively working for the minimum number of hours required by the employer's Joinder Agreement.

All losses of eligibility that have occurred by the first day of the month stated above have already been reported on a "Notice to Terminate TPM Trust Benefits" form prior to the first day of the above month of coverage.

I also understand that if the TPM Trust administers my employer's COBRA services, including Oregon Continuation Coverage, I am obligated to provide notice to the TPM Trust within 30 days of a participant's qualifying event on a "COBRA Qualifying Event" form.

I understand that failure to report loss of eligibility by the first business day after coverage terminates may have financial consequences for the employer. Further, I understand that if the employer misreports or fails to report accurate employee eligibility information, the employer shall be obligated to reimburse the Timber Products Manufacturers (TPM) Trust for any claims paid on behalf of its employees or dependents for medical expenses incurred after the date that their eligibility for coverage ends.

NAME OF EMPLOYER	SIGNATURE	DATE

THIS FORM MUST BE RETURNED TO

TPM TRUST
c/o Rehn & Associates
P.O. BOX 5433
SPOKANE, WA 99205

IF YOU HAVE ANY QUESTIONS, CALL 1-877-535-4646.