ATTESTATION

FOR

Revoking coverage due to the employee being enrolled, or immediately will enroll, in other health coverage not sponsored by Imagine Early Learning Centers, LLC

Employee Full Name (do not initial): _____

I attest that I am enrolled in, or immediately will enroll in, one of the following types of coverage, with an effective date of _____:

1. Employer-sponsored health coverage through the employer of my spouse or parent
2. Individual health insurance coverage enrolled in through the Health Insurance Marketplace (also known as the Health Insurance Exchange)
3. Medicaid
4. Medicare
5. TRICARE
6. Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
7. Or other coverage that provides comprehensive health benefits (for example, health insurance purchased directly from an insurance company or health insurance provided through a student health plan)

I understand that I must provide Identifying information as requested by Imagine Early Learning Centers for administrative purposes.

Employee Signature:

_____