CERTIFICATION OF ERISA STATUS

This certification is made by:

Health Care Service Contractor, Health Maintenance Organization, or
Disability Insurance Company: _____

Representative Contact Name: _____

Relationship to Company/Contractor: _____

Pharmacy Benefit Manager (PBM): _____

PBM Contact Name: _____

Relationship to the PBM: _____

WAOIC Number: _____

I certify that:

I. Authority

I am a representative of the Health Care Service Contractor, Health Maintenance Organization, or Disability Insurance Company and have the authority to make this certification.

II. ERISA Plan

- ☐ This claim is covered by an ERISA plan, or
- ☐ This claim is covered by a non-ERISA plan, or
- ☐ This claim is covered by a Medicare plan, or
- ☐ This claim is covered by a Medicaid plan.
- ☐ Other: _____

Policy Number: _____

Documents relied upon in making the ERISA Certification

<u>MUST</u> be submitted with this Form.

If you fail to provide supporting documentation, this certification may be rejected

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signed at (City)_____, (State) _____ on (Date)_____.

_____ _____

Signature of Declarant Print or Type Name