HALDANE

SHARED SAVINGS FORM

To Be Completed by Employee:

I _____hereby certify that I am covered under the

_____health insurance plan as evidenced by the attached photocopy

of my medical insurance card(s).

Employee Signature: _____ **Date:** _____

Acknowledgement to be Completed by Notary:

STATE OF _____COUNTY OF _____

ON THIS _____ DAY OF _____

Before me personally appeared _____ to me known and known to be the person described in and who executed the foregoing instrument, and he/she duly acknowledged to me that he/she executed same.

Notary Public: _____

(Please sign, affix stamp and include expiration date)

For Internal Purposes:

Bargaining Unit _____

Coverage Level Waived _____

Shared Savings Amount _____