

CorCare® Certified Texas HCN Attestation A

CorCare® Certified Texas HCN Election Form – To be completed by employer

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Designated Staff Member’s Name Responsible for Rollout: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Completed Employer Responsibilities**

1. **Reviewed** the *Texas CorCare® Network Requirements and Employee Acknowledgment Form* which includes all of the information the employee needs to know about the CorVel CorCare® HCN program.
2. **Developed and documented** a policy and procedure for dissemination of the packet to all employees. To comply with the law, this process included the method of delivery, to whom the notice was delivered, and the date(s) of delivery.
3. **Distributed** the *Texas CorCare® Network Requirements and Employee Acknowledgment Form* to all current employees (full and part-time) upon implementation of the program. We will continue to provide this packet also within 3 days of hire and again at time of injury.
4. **Posted** the *Texas CorCare® Network Requirements* at each place of employment.

I acknowledge the responsibilities listed above are the responsibility of the policyholder and have been completed.

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Signature Employer

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Printed Name Date Signed *(Effective HCN)*

Please sign and email this document to: Chubb