



CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community

EMPLOYEE INVOLUNTARY TERMINATION / RESIGNATION EMPLOYER ATTESTATION STATEMENT

Name of District: _____

Name of Employee: _____

Employee's Social Security Number (last four digits) _____

Date of Termination / Resignation: _____

I, _____ attest to the following:

1. I hold the position of _____ with
_____ ("District")
2. I have personal knowledge of the facts stated herein and am competent to attest to them.
3. _____ was involuntarily terminated or involuntarily resigned
from his/her position with the District on _____

I certify that the responses in this attestation are accurate, complete, and current as of this date:

Signed: _____
(Signature of Authorized Representative)

(PRINT Name of Signature)

Title: _____
(Title of Authorized Representative acting on behalf of the District)

Date: _____