CorCare® Certified Texas HCN Attestation A

Policyholder: _____ Quote/Policy Number: _____

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.

4. **Posted** the *Texas CorCare® Network Requirements* at each place of employment.

I acknowledge the responsibilities listed above are the responsibility of the policyholder (employer) and they have been completed.

_____ _____
Signature Employer

_____ _____
Printed Name Date

Please sign and mail this document to:

Acuity, A Mutual Insurance Company
Underwriting Department
2800 South Taylor Drive
Sheboygan, WI 53081