Individual Coverage HRA Model Attestation: Annual Coverage Substantiation Requirement

HealthOne

Instructions: You have been offered an Individual Coverage Health Reimbursement Arrangement (HRA) to help you pay for medical care expenses. To enroll in this individual coverage HRA, you must be enrolled in individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage). You should have received a notice that describes the individual coverage HRA that you are being offered. If you have not, or if you have questions about the Individual Coverage HRA, contact your benefit coordinator, human resources department or HealthOne Alliance (ICHRA Administrator) at 706-671-6448.

If you plan to enroll in the Individual Coverage HRA, you must complete this form to confirm that you will have individual health insurance coverage, Medicare Part A and B, or Medicare Part C while you are covered by the HRA. If your family members will also be covered by the Individual Coverage HRA, you need to fill out the applicable section of this form on their behalf.

You must sign and date the form. Your family members do not need to sign or date the form. Please return the completed form via email to: Assist@HealthOneLLC.com or regular US Mail to: HealthOne Alliance, ATTN: ICHRA Admin., PO Box 1128, Dalton, GA 30722.

I attest to the following:

I, _____, am covered (or will be covered) by the following health coverage:
(full name)

_____.
(name of insurance company or "Medicare")

This health coverage began (or will begin) on _____.
(date coverage began or will begin)

Instructions: Complete the following if you plan to enroll a family member in the individual coverage HRA. If more than one family member will be covered by the individual coverage HRA, fill out the information for each family member.

Employee's Spouse, _____, is covered (or will be covered) by the following
(full name)

health coverage: _____.
(name of insurance company or "Medicare")

The following non-spouse dependent(s), _____, _____,
(full name) (full name)

_____, _____, _____,
(full name) (full name) (full name)

_____, _____, _____,
(full name) (full name) (full name)

is/are covered (or will be covered) by the following health coverage: _____.
(name of insurance company or "Medicare")

This health coverage began (or will begin) on _____.
(date coverage began or will begin)

I hereby affirm that the above information is true and accurate.

Signed: _____ Date: _____
(sign your name)

Reminder: To open and fund your IC-HRA, you will need to submit this form and the Individual Coverage HRA Individual/Family Plan Coverage Documentation.