HRASimple

# Individual Coverage HRA Model Attestation: Ongoing Substantiation Requirement

Instructions: To receive reimbursement for medical care expenses under your Individual Coverage Health Reimbursement Arrangement (HRA), you must complete this form for each request for reimbursement.

The Individual Coverage HRA will reimburse you for a medical care expense incurred during a month only if you have money in your account not being used to pay premiums (or had) individual health insurance coverage, Medicare Part A (Hospital Insurance) and B (Medical Insurance), or Medicare Part C (Medicare Advantage) during that month. Similarly, the individual coverage HRA will reimburse you for a medical care expense your family member incurred during a month only if the family member has (or had) individual health insurance coverage, Medicare Part A and B, or Medicare Part C during that month. For HDHP (HSA-qualified plan beneficiaries), reimbursement can only be made once the deductible is met. In this form, you are attesting that you (or your family member) meet this requirement.

**You must sign and date this form and attach a receipt or other substantiation for the expense. Your family member does not need to sign or date the form.** Please return the completed form to: Assist@HRASimple.com or regular US Mail to: HRASimple, ATTN: ICHRA Admin., PO BOX 1128, Dalton, GA 30722. If you have questions, please call 888-851-9613.

Complete the following if you're requesting reimbursement of your medical care expense from the individual coverage HRA.

I attest to the following:

I, _____, am requesting reimbursement for a medical care expense incurred during
(full name)

_____, and for that month I am (or was) covered under the following health
(month, year)

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

Instructions: Complete the following if you're requesting reimbursement of a family member's medical care expense from the individual coverage HRA.

I, _____, am requesting reimbursement in the amount of $_____for a medical care
(full name)

expense incurred by _____, during _____, and for that month
(full name of family member) (month, year)

this family member is (or was) covered under the following health coverage:

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

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

Signed: _____
(sign your name)

Date: _____