SAMPLE MUST BE PERSONALIZED WHERE INDICATED BEFORE USE

Individual Coverage HRA Model Attestation: Annual Coverage Substantiation Requirement

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 [*add contact information*].

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 to [*add instructions for returning the form*]. You must return the form by [*add deadline for returning the form*.]

I attest to the following:

I, _____, am covered (or will be covered) by the following health
(insert name)
coverage: _____.
(insert name of insurance company or indicate "Medicare")
This health coverage began (or will begin) on _____.
(insert 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 a form for each family member. [*This section may also be copied to allow a participant to list all family members on a single form*.]

The following family member, _____, is covered (or will be covered) by
(insert name)
the following health coverage: _____.
(insert name of insurance company or indicate "Medicare")
This health coverage began (or will begin) on _____.
(insert date coverage began or will begin)

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

Signed: _____

Date: _____