ICHRA EXPENSE CLAIM FORM

Name _____ **SSN** _____

Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as proof that the claim is not being reimbursed by other coverage. Also, you will not be entitled to claim any reimbursed expenses as a tax deduction.

Date of Service	Person Incurring Expense	Relationship	Provider	Description of Service	Amount Requested
				Total Amount of Medical Reimbursement Requested	$

HEALTH INSURANCE PREMIUM INFORMATION (please attach a copy of the premium)	
NAME OF INSURANCE COMPANY	
INDIVIDUAL(S) COVERED BY POLICY	
POLICY NUMBER	
COVERAGE DATES FOR THIS PREMIUM PAYMENT	_____ / _____ / _____ - _____ / _____ / _____
Total Amount of Premium Reimbursement Requested	$

I certify that the information above is true to the best of my knowledge and that my spouse (if applicable), dependents (if applicable), and I are covered under a minimum essential coverage health plan as defined by the Affordable care Act for all dates for which I am claiming expenses under my ICHRA plan. I understand that failure to maintain minimum essential coverage for any month will result in any reimbursements received from this ICHRA to be taxable. I also certify that all reimbursement requests submitted are IRS eligible expenses and I have not been reimbursed for these expenses in the past or I am not seeking reimbursement for these expenses from any other source.

_____ _____

Employee Signature Date

Change of address? ☐ No ☐ Yes New Address: _____

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