20__ ICHRA Application

Applicant Information		
Name:		
Date of birth:	SSN:	Phone:
Address, City, State, and ZIP:		

Employment Information		
Employer:		
Employer Address, City, State, and ZIP:		
Phone:	How long?	
Position:	Expected Hours Worked Per Week:	

I Understand…	
I am applying to be in an ICHRA: Yes / No	I agree to the terms of the ICHRA: Yes / No
I understand my Employer can change the Plan provisions at any time: Yes / No	
I understand my Employer will establish an ICHRA account to be used for reimbursement of individual health insurance policy premiums: Yes/No	
I understand the ICHRA is a “use it or lose it” arrangement: Yes / No	
I understand that I have an established time within which to submit claims for reimbursement of individual health insurance policy premium expenses: Yes / No	

Spouse and Dependents Covered In This Agreement		
Spouse:	Date of Birth:	SSN:
Dependent:	Date of Birth:	SSN:
Dependent:	Date of Birth	SSN:

Individual Health Insurance Policy Information	
Insurance Company Name:	
Address, City, State, and ZIP:	
Coverage (Circle All Who Are Covered By This Policy): Employee Spouse Dependents	
Annual Premium for All Covered By This Policy: $	

I understand that any amounts remaining in my ICHRA account at the end of the Plan Year after all eligible reimbursements have been made will be forfeited.

Signature of applicant:	Date:
Signature of Employer:	Date