ACCRUE HEALTH

ICHRA EMPLOYEE ENROLLMENT FORM

Only used for **NEW** employees being added to existing groups if Census spreadsheet is **NOT** submitted.

_____(Group Name) has established an Individual Coverage Health Reimbursement Arrangement Plan ("ICHRA Plan") to help employees pay a portion of their individual health insurance premiums. Please read and complete the form below to indicate your participation in ICHRA.

☐ **I ELECT to participate in my employer's HRA Plan. By checking this box, I acknowledge that:**

- I am currently enrolled, or intend to enroll, in individual health insurance or Medicare. I intend to remain enrolled in such coverage for so long as I participate in the ICHRA Plan.
- I hereby authorize the ICHRA Plan to make monthly premium payments from my ICHRA Plan account: directly to the insurance carrier I have selected or other entity accepting premiums for my individual health insurance or Medicare coverage, up to the amount available in my ICHRA Plan account at the time of each payment.
- Such payments shall continue unless I either: (1) stop participating in the ICHRA Plan, or (2) revoke this authorization as described below.
- I agree to provide the ICHRA Plan (or its administrator[s]) any documentation, as and when it may request or require, showing my enrollment in individual health insurance or Medicare coverage.
- I understand that I may choose to enroll in any individual health insurance or Medicare coverage for which I am eligible (and which is eligible for reimbursement under the terms of the ICHRA Plan). Neither my employer, any administrator(s) of the ICHRA plan, nor any entity affiliated therewith endorses, requires, or encourages my selection, enrollment or renewal with any product, plan, carrier or program.
- I may revoke the above authorization at any time by providing written notice to:
  Enrollment.AccrueHealth@BCBSSC.com or
  AccrueHealth
  P.O. Box 100177, AX-G10
  Columbia SC 29202

IF YOU WISH TO PARTICIPATE IN THE EMPLOYER ICHRA PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name_____
(First) (Middle) (Last)

Birthdate_____/_____/_____ Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Mailing Address_____City_____State_____Zip_____

Phone Number_____ Email Address_____

Individual enrollment complete ☐ Yes ☐ No Type of coverage ☐ ACA ☐ Medicare ☐ Medicare Supplement ☐ Part D

Carrier_____

Applicant's Signature _____ **Date** _____

Print Name_____

TO BE COMPLETED BY EMPLOYER

Monthly Contribution Amount: $_____

Class:_____