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 (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. In this form, you are attesting that you (or your family member) meet this requirement. [*If this form is not combined with the form used to seek reimbursement of medical care expenses, add a statement that the reimbursement form is separate.*]

You must sign and date this form. Your family member does not need to sign or date the form. Please return the completed form to [*add instructions for returning the form, including any applicable deadline*].

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
(insert name)
expense incurred during _____, and for that month I am (or was) covered under
(insert month, year)
the following health coverage:_____.
(insert name of insurance company or indicate "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 for a medical care expense
(insert name)
incurred by _____, during _____, and
(insert name of family member) (insert month, year)
for that month this family member is (or was) covered under the following health coverage:

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

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

Signed: _____

Date: _____