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.

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

Effective Date _____

Name _____
(First) (Middle) (Last)

Birthdate ____/____/____ Gender _____ Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Physical Address _____ City _____ State _____ Zip _____

Billing Address _____ City _____ State _____ Zip _____
(If different then physical address)

Phone Number _____ Email Address _____

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

If No, please provide the information below:

SEP Date ____/____/____ Are you covered by Medicare ☐ Yes ☐ No

Individual ACA Plan Selected _____ ☐ US Citizen ☐ US National

Preferred Method of Communication _____ Are you enrolling any dependent on your health plan ☐ Yes ☐ No

If you have Individual coverage with another Carrier, please provide the below information:

Coverage type: ☐ Out of State ☐ Medicare ☐ Other Carrier

Name of Carrier: _____

If you have one of these types of coverages, you are required to submit proof of payment each month to Enrollment.Accruehealth@bcbssc.com to be reimbursed.

Applicant's Signature _____ **Date** _____

Print Name _____

TO BE COMPLETED BY EMPLOYER

Monthly Contribution Amount: $_____

Class: _____

*By submitting this Enrollment Form, you permit BlueCross to draft the Group's bank account for the ICHRA contribution amount