Individual Coverage HRA Individual/Family Plan
Coverage Documentation

HealthOne

☐ New Account Setup ☐ Change Account Setup

Instructions: *To properly set-up your Individual Coverage HRA, please provide the following documentation about the coverage you have purchased, in addition to the IC-HRA: Annual Coverage Substantiation Requirement form.*

I, _____, am covered (or will be covered) by the following health coverage:
(full name)

_____(include which State the insurance company is in).
(name of insurance company or "Medicare")

Your **county** of residence: _____.

Date your health plan coverage begins: _____.
(date coverage began or will begin)

The application ID (or policy number): _____.
(the ID is a unique number for your policy)

The monthly premium for this policy: _____.
(the total $ amount you are required to pay each month)

Covered on your health plan:

Employee:_____ Spouse:_____ Children (how many):_____

YOU MUST ELECT ONE *(only one)* of the following two choices:

☐ **I DO want the IC-HRA Administrator to make payments from my HRA account to the insurance company, on my behalf.** This election requires payroll deduction in the event your monthly premiums exceed the monthly HRA contribution by your employer.

☐ **I DO NOT want the IC-HRA Administrator to make payments to the insurance company, on my behalf.** I will make those payments and understand that to be reimbursed a receipt and documentation of my premium payment must be properly submitted to the Administrator. **Payment must be made before coverage will start.** To keep coverage active, payment must be made each month *(within the grace period offered by the insurance company, which is usually no more than 31-days).*

You must sign and date the form. Your family members do not need to sign or date the form. Please return the completed form and your first bill via email to: Assist@HealthOneLLC.com or regular US Mail to: HealthOne Alliance, ATTN: ICHRA Admin., PO Box 1128, Dalton, GA 30722. If you have questions, please call (706) 671-6448.

Please allow 5 (five) business days to process a request for reimbursement.

PRINT Your Full Name: _____ Work Status (please check):

SIGN Your Name: _____ ☐ Full Time ☐ Part Time ☐ PRN

Your HLTC Associate ID #: _____ Your Date of Birth:_____

Your Phone: _____ Email:_____ Your Department: _____

Date: _____