AMERICAN BENEFITS GROUP

INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENT (ICHRA) – ENROLLMENT FORM

You must complete and return this form. Please print.

Name: _____ Social Security #: _____

Home Address: _____ Email: _____

City, State, Zip: _____ Phone: _____

Date of Birth: _____ Gender _____ Employer/Division: _____

☐ **Single Coverage**

☐ **Family Coverage - Please Complete the Following Dependent Information**

Last Name_____ First Name _____ Date of Birth ____/____/____
Dependent's SS#:_____ Relationship: Spouse ☐ Domestic Partner ☐ Gender: M ☐ F ☐

Last Name_____ First Name _____ Date of Birth ____/____/____
Dependent's SS#:_____ Relationship: Child ☐ Gender: M ☐ F ☐

Last Name_____ First Name _____ Date of Birth ____/____/____
Dependent's SS#:_____ Relationship: Child ☐ Gender: M ☐ F ☐

I HEREBY CERTIFY that:

- The information I have provided above is true and accurate;
- I have enrolled myself and my dependents in eligible individual health coverage; and
- I understand that I cannot receive any reimbursement until I provide evidence of our enrollment in such coverage and I have to provide such evidence each month thereafter by completing an Expense Reimbursement Form.

_____ _____
Employee Signature Date

_____ _____
Employer Signature Date

Fax Toll Free: 877-723-0147 or email to processing@amben.com

No Fax Machine? Mail to: American Benefits Group
PO Box 1209 | Northampton, MA 01061-1209 | 800-499-3539