



ICHRA Enrollment Form

Employees: Complete and return this form to your Human Resources representative

Employers: Collect the completed forms from employees and follow the instructions at info.empowerflex.com/enrollment-instructions/ to submit enrollment. Keep the completed forms for your records.

Employer _____	SSN (last four only) _____
Employee Name _____	Hire Date ____/____/____
Email _____	
Employee ID _____	Date of Birth ____/____/____
Home Address _____	Work Phone (____) ____-____
City _____ State ____ Zip _____	Mobile Phone (____) ____-____

Option 1: ICHRA Opt-Out

<input type="checkbox"/>	I Wish to opt out of the ICHRA
I confirm that I have received the ICHRA notice and wish to opt out of the ICHRA.	

Option 2: Enroll in ICHRA

To be eligible for ICHRA reimbursement, you must enroll in individual coverage health insurance. Please fill out the below attestation to be eligible for ICHRA reimbursement.

I, _____, am covered under the following health coverage (name of insurer coverage): _____.

The coverage began/begins on: _____.

Also complete the following if a family member's expenses can be reimbursed from the ICHRA.

The following family member(s) _____ is/are covered under the following health coverage (name of insurer coverage): _____.

The coverage began/begins on: _____.

Employee Signature _____	Date ____/____/____
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