ICHRA Enrollment/Change/Waiver Form

Name: ______________________________ Effective Date: ____________________

Marital Status: __________ Date of Hire: ______________ Soc. Sec. ____________________

Employee Address: ____

Email: ______________________________ Phone Number: ____________________

I prefer to be contacted regarding my ICHRA via: Email ______ Telephone ______ 1st Class Mail ______

Action to be taken:

Enroll in ICHRA Plan

Change in Covered Dependents

Waive Coverage

I select the following coverage option:

Employee Only

Employee & Family

List of Participants:

Last Name	First Name	**Relationship** (Self, Spouse or Child)	M/F	SS#	Date of Birth	**Medicare Eligible** (Y or N)

Please Note: You must complete a new Enrollment Form within 30 days of a qualifying event to add eligible family members.

Authorization and Agreement:

I have read the Individual Coverage Health Reimbursement Arrangement Summary Plan Description and agree to abide by the terms of the Plan Document. I recognize I must submit third party substantiation/EOB and a Reimbursement Request Form to the Plan's Administrator for the reimbursement of qualified expenses, as determined by the Plan Administrator. I recognize that any expenses I submit for reimbursement must not be reimbursed by any other source tax-free or otherwise. I understand that I will have three months in which to submit qualified expenses following the close of a Plan Year, or upon termination of participation.

Employee's Signature: ______________________________ Date: ______________

Please return the completed form to Fronteer Professional Services, Inc., 1838 E Interstate Ave Ste B, PO Box 1315, Bismarck, ND 58502. Fax: (701) 258-1011. Email: customerservice@fpspayroll.com.