



HRA Annual Medical Coverage Attestation Application

By law, and because you are not covered by the North Atlantic States Carpenters Health Benefits Fund, ("Fund") the Health Reimbursement Arrangements ("HRA") administered by the Fund must confirm on an annual basis that you are enrolled in another group health plan that meets the minimum value standard of the Affordable Care Act ("ACA") in order for employer contributions to be credited to your HRA account.

If you receive health coverage through your employer or your spouse's employer, you should have received a

Summary of Benefits and Coverage indicating whether the plan meets the ACA minimum value standard. If you're unsure, please contact your health plan for clarification. Please contact the Fund Office with any additional questions.

In order to retain access to your HRA account, the Fund office must receive this completed form within 30 days. Failure to do so will result in suspension of your account and will be subject to administrative fees. [This form is valid up to 1 year.](#)

Please complete all sections that apply, sign, and submit with a copy of your insurance cards within 30 days to retain access to your HRA account.



Name: _____

SSN: _____

Address: _____

Date of Birth: _____

Primary Contact number: _____

Email: _____

☐ I am enrolled in my employer's group health plan.

☐ I am enrolled in my spouse's employer group health plan.

Name of Employer: _____

Name of Insurance Company: _____ Policy Start Date: _____

Coverage Tier

Please select one:

☐ Single

☐ Family

Coverage Type

Select all that apply:

☐ Medical

☐ Vision

☐ Dental

☐ Prescriptions

Does the Health Plan meet minimum value/coverage standard?

Please select one:

☐ Yes

☐ No

☐ **I am enrolled in Medicare.**

Name of Primary Insured: _____

Name of Employer: _____

Name of Insurance Company: _____ Policy Start Date: _____

Coverage Tier

Please select one:

☐ Single

☐ Family

Coverage Type

Select all that apply:

☐ Medical

☐ Vision

☐ Dental

☐ Prescriptions

Does the health plan meet minimum value standard?

Please select one:

☐ Yes

☐ No

☐ **I am enrolled only in Medicaid or a state marketplace health plan.**

Name of Employer: _____

Name of Insurance Company: _____ Policy Start Date: _____

Coverage Tier

Please select one:

☐ Single

☐ Family

Coverage Type

Select all that apply:

☐ Medical

☐ Vision

☐ Dental

☐ Prescriptions

Does the health plan meet minimum value standard?

Please select one:

☐ Yes

☐ No

☐ **I am not enrolled in any Health Plan.**

- As of the date indicated below, I am enrolled in a Group health plan that meets the minimum value standard of the Affordable Care Act.
- I understand that I must notify the Fund immediately if and when I am no longer enrolled in a Group health plan that meets the minimum value standard of the ACA.
- I agree to indemnify the Fund and its Trustees from any losses caused by any misstatements made herein.

Participant Signature: _____

Date: _____