QESHRA & ICHRA Reoccurring Claim
Monthly Premium

Employer Name:	
Employee Name:	
Claimant Name:	
Employee Address:	
Email Address:	
Health Plan Information - MUST be an Individual Medical Plan that meets ACA Minimum Essential Coverage	
Health Insurance Carrier:	Plan Name (Example-Standard Silver):
Coverage Period:	
Monthly Premium Request:	

Reimbursements are issued **via direct deposit only**. An active bank account must be on file to receive reimbursement. Please log in to your member portal to review and confirm your direct deposit information. Fees may apply if bank information is incorrect or inactive. Any additions or changes to direct deposit details must be made through the member portal.

I hereby certify that all information provided above, as well as any accompanying documentation, is true, accurate, and complete to the best of my knowledge. I acknowledge and agree to notify Healthy Dollars in writing and without delay of any changes to my recurring payment information, including but not limited to changes in monthly premium amounts. I understand that failure to provide timely notification may result in additional tax consequences, for which I assume full responsibility.

Employee Signature: _____ Date: _____

Please send completed forms and documentation to:
Email: **Claims@healthydollarsinc.com**
For Questions, please call 802-876-5072.