To: _____

RE: Employer Attestation Statement of ACA-Compliant Group Health Coverage

Date: _____

I am writing because the _____ reimburses employees for qualified medical expenses under a **Health Reimbursement Account (HRA)**. Historically, eligible employees have been able to access this benefit even if they were not enrolled in our group health plan.

The *Affordable Care Act* (ACA), however, instituted new regulations governing reimbursements from an HRA for employees who do not enroll in their employer's group health coverage. Consequently, to continue to allow employees who waive coverage in our group health plan to participate in our HRA, we must secure the attestation statement below for each affected employee.

Our employee, _____**,** has told us that [s/he] has coverage under and is enrolled in your group health plan. If this is true, and your plan meets the conditions outlined below, please (a) sign the attestation statement, (b) provide us with your contact information, and (c) return the document to our employee directly or via the worker you employ whose dependency coverage extends to our employee.

If you have any questions about this statement, call or e-mail _____ at _____.

If you need to verify that your health insurance plan is ACA compliant and meets the federal law's minimum value requirements, we recommend that you contact your insurance carrier or broker.

Important Time Saver: If your group coverage is with **Vermont Health Connect** (the new state "Exchange") or you offer group coverage through **VEHI**, the Vermont Education Health Initiative, your employer-sponsored coverage is ACA compliant and satisfies minimum value requirements.

Employer's Attestation Statement:

Our employee, _____, is enrolled in a group health insurance plan offered by our organization. Our group plan is ACA compliant and meets the federal law's minimum value requirements.

Date: _____

Signature: _____, _____ [Company Title]

Please print your name: _____

Telephone Number & E-Mail Address: _____

Company/Employer: _____

Employee Attestation Statement: Health Reimbursement Account Benefits

I, _____, am enrolled in group health insurance coverage with _____**,** in _____.

I am employed by the _____ and am eligible for reimbursements from the district's Health Reimbursement Account (HRA).

I agree to notify the school district should my health insurance coverage with the _____ **terminate for any reason**. I will provide this notification to the school's business manager or designated representative in writing prior to the date of termination of my insurance coverage.

I understand that if I seek to be reimbursed from my school district's HRA for qualified medical services incurred after the date my group health coverage with _____ terminates, *and* I was not enrolled in the district's health plan when the medical services I am seeking reimbursement for were provided, my actions may not be legal and could result in personal tax penalties.

Signature of Employee: _____

Date: _____