Lake Superior School District
INTEGRATED HEALTH REIMBURSEMENT ACCOUNT

INSURANCE SUBSTANTIATION FORM

Instructions: Completion required only when enrolling in the Integrated HRA Plan ISD #381employee, have <u>your spouse</u> take this form to his/her employer for completion. Submit this form along with the Enrollment form.

Dear Employer,

Your employee's spouse is being offered the opportunity to participate in an employer sponsored Integrated HRA Plan. This will allow them to submit incurred out-of pocket medical, dental and vision expenses for reimbursement. The criteria for plan eligibility is the Lake Superior School District employee must provide proof they have group health insurance coverage under your employer plan. This form was created to simplify and expedite the substantiation process.

Please fill out the form and return it to your employee. Thank you for your cooperation. If you have questions, please call (800-447-1690).

Compensation Consultants, Ltd.
P.O. Box 720
Cloquet, MN 55720

Your Company's Name:_____

Your Company's Address:_____

Your Company Phone Number:_____

Your Employee's Name:_____
(please print)

Your Employee Spouse's Name:_____
(please print)

Does Your Employee's Spouse Have Health Insurance Coverage Under Your Company's Employer Sponsored Health Plan? ❑ Yes ❑ No

Is your Health Plan a High Deductible Health Plan and contributions are made to a Health Savings Account (HSA)? ❑ Yes ❑ No

AFFIRMATION:

To the best of my knowledge and belief, my statement in this request for health insurance coverage substantiation is accurate and true.

Employer Signature:_____

Title:_____

Date: _____/ _____/ _____

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