SUPERIORUSA CORPORATION
Payroll & Employee Benefits Consultants

Proof of Insurance Coverage (MEC) Form

Instructions: *To begin receiving reimbursements for expenses you are eligible for under your employer's QSEHRA Plan during this plan year, you must submit proof of and certify that you are maintaining health insurance coverage that meets Minimum Essential Coverage (MEC) prior to receiving any reimbursements for individuals, which may include your spouse and qualified dependents, who have that coverage. This form must be re-submitted annually for each new plan year or anytime during the current plan year where there is a change in coverage under you or your family's health insurance (MEC). This form should be submitted directly to SuperiorUSA via fax or mail.*

SECTION 1: EMPLOYEE INFORMATION *(Please Print)*

Name (Last, First, MI)		Social Security Number	Date of Birth
Employer	Preferred Phone Number	Email Address	

☐ Change of Address: _____

SECTION 2: INSURANCE COVERAGE (MEC) SUBSTANTIATION *(Please Print)*

An itemized payment receipt or billing statement for insurance premiums, insurance ID card, Explanation of Benefits (EOB) from recent activity, or other source documentation from your health insurance provider must be attached.

Name of Insured	Relationship of Insured to Participant/ Employee	Date Coverage Began	Date Coverage Ends (Renews)	Name of Health Insurance Provider and Specific Plan or Policy	HDHP?
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SECTION 3: ELECTION TO PRESERVE HSA CONTRIBUTION ELIGIBILITY *(Please Print)*

By checking this box, I elect to restrict my entire QSEHRA account to qualifying expenses that will preserve my eligibility for HSA contributions for the remainder of the year, including only reimbursing from my QSEHRA for vision, dental, preventative care, and post-minimum HSA deductible expenses. ☐

SECTION 4: EMPLOYEE SIGNATURE

I, the undersigned, hereby submit valid substantiation as required by my employer's QSEHRA Plan and IRS regulations of my coverage under a health insurance plan meeting Minimum Essential Coverage (MEC). I certify and attest that the above information is true, accurate, and complete, and that I, my spouse, or a qualified dependent currently have and will continue to maintain the coverage meeting MEC throughout the plan year. I have confirmed with my health insurance provider that my coverage meets Minimum Essential Coverage (MEC) and am not relying on SuperiorUSA or my employer to determine if my coverage qualifies as MEC. If there is a change in the coverage (such as which family members are insured), I agree to immediately notify SuperiorUSA. I understand that I alone am responsible for compliance with applicable tax regulations and documentation maintenance requirements, and that I agree to indemnify and hold harmless my employer and SuperiorUSA for any liability resulting from my reimbursements and participation in the program.

Employee Signature: _____ **Date:** _____

Completed forms must be submitted along with required supporting documentation directly to SuperiorUSA Corporation. Claims may be faxed (218-725-9161 or 877-422-5192), emailed, or mailed. Please visit our website at www.superiorusa.com, email, or call (877) or (218) 529-2477 with questions.

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