Recurring Insurance Premiums
ICHRA Plans Only

EMPLOYER: _____

EMPLOYEE NAME: _____ SSN: _____

ADDRESS:_____

CITY, STATE, ZIP:_____

EMAIL:_____

The provider charges a set amount of $ _____

per: ____ Week ____ Bi-weekly ____ Monthly ____ Hour ____

Other_____

Rates are effective for: _____/_____/_____ to _____/_____/_____

Provider Name:_____

Please include copy of a monthly statement/invoice for verification.

Employee Signature: _____Date: _____ /_____ /_____

SEND TO: AWM

FAX: 855-265-1830 EMAIL: SUPPORT@AWM.CC