**The MEMPHIS Plan**
Healthcare Advisory Team
1350 Concourse Ave, Ste. 142
Phone 901-272-7526
MP Fax 901-278-6622
ChurchHealth.org/Memphis-Plan/

# Annual Employee Eligibility Attestation

Group #: _____ Account Name: _____

Date: _____ Completed By: _____
(MEMPHIS Plan Representative)

**Dear MEMPHIS Plan Employer,**

The MEMPHIS Plan provides essential services to employees with limited access to healthcare, made possible through the generosity of our medical community. To simplify annual eligibility verification, the MEMPHIS Plan is asking each participating employer to complete this annual attestation.

**Employee Eligibility Requirements**

• Work at least 20 hours per week; and

• Have family income at or below 200% of the Federal Poverty Level, based on income and family size.

**2026 Federal Poverty Guidelines (200% FPL)**

| Family Size | Maximum Household Annual Income |
|---|---|
| 1 | $31,920 |
| 2 | $43,280 |
| 3 | $54,640 |
| 4 | $66,000 |

**Annual Employer Attestation**

I certify that, on behalf of the employer account identified above, I will ensure that each employee currently enrolled in or enrolling in the Plan meets the MEMPHIS Plan eligibility requirements stated above. I understand that eligibility must be verified for current and future enrollments and that I am responsible for notifying the MEMPHIS Plan team if an enrolled employee no longer meets the eligibility requirements. I certify that the information provided in this attestation is accurate to the best of my knowledge.

**Employer Representative Name:** _____

**Signature:** _____

**Title:** _____

**Date:** _____ **Phone:** (_____)_____

**Please return the completed attestation to memphisplan@churchhealth.org.**

Deadline: November 15, 2026