EMPLOYER HEALTH PREMIUM REIMBURSEMENT RETURN

Tax & Benefit Year:

EMPLOYER INFORMATION

Employer Name

Employer Identification Number (EIN)

Mailing Address

Contact Person

Phone Number / Email

Reporting Period (Quarter/Month)

SCHEDULE OF HEALTH PREMIUM REIMBURSEMENTS

Employee ID	Employee Name	Total Premium Paid	Reimbursement Amt	Proof of Payment (Y/N)
	Total Reimbursements Claimed:			

EMPLOYER DECLARATION & AUTHORIZATION

I hereby certify, under penalty of perjury, that the employer contributions and health premium reimbursements listed above were paid to or on behalf of the eligible employees in accordance with established company health plans and applicable statutory guidelines. I maintain all necessary receipts, invoices, and proofs of coverage to substantiate these claims.

Authorized Employer Representative Signature

Date (MM/DD/YYYY)