Monthly Employee Benefits Payroll Contribution Ledger

Company Name: _____ **Pay Period:** _____

Month / Year: _____ **Date Prepared:** _____

EMP ID	EMPLOYEE NAME	DEPARTMENT	EMPLOYEE PRE-TAX CONTRIBUTIONS			EMPLOYEE POST-TAX		EMPLOYER SHARE (MATCHING)	TOTAL PREMIUM
			MEDICAL	DENTAL	VISION	LIFE INS.	OTHER		
		Total:							

_____ _____ _____

PREPARED BY REVIEWED BY AUTHORIZED SIGNATURE