ANNUAL EMPLOYER HEALTH INSURANCE CONTRIBUTION RETURN

Tax Year: 20_____

1. EMPLOYER IDENTIFICATION & INFORMATION

EMPLOYER / COMPANY NAME

EMPLOYER IDENTIFICATION NUMBER (EIN)

PHYSICAL ADDRESS

CONTACT PERSON

EMAIL ADDRESS

TELEPHONE NUMBER

2. MONTHLY CONTRIBUTION SUMMARY TABLE

MONTH	NUMBER OF COVERED EMPLOYEES	TOTAL MONTHLY PREMIUM PAID	EMPLOYER CONTRIBUTION SHARE
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			
TOTALS			

3. RECONCILIATION & TOTALS

TOTAL ANNUAL HEALTH INSURANCE PREMIUM COST

TOTAL ANNUAL EMPLOYER CONTRIBUTIONS PAID

ELIGIBLE TAX CREDIT (IF APPLICABLE)

NET EMPLOYER HEALTH CONTRIBUTION REPORTED

4. DECLARATION & AUTHORIZATION

I declare under penalties of perjury that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete.

AUTHORIZED SIGNATURE

TITLE

DATE

This document serves as an annual administrative report for employer health insurance contributions. Retain a copy of this return and all supporting health insurance invoices for audit purposes.