EMPLOYER HEALTH INSURANCE CONTRIBUTION RETURN

Monthly / Quarterly Return Statement

Company Name:

Employer Tax ID / EIN:

Company Address:

Reporting Period:

Insurance Provider:

Policy Number:

S.N.	Employee ID	Employee Name	Total Premium ($)	Employer Share ($)	Employee Share ($)

Total Premium:	
Total Employer Contribution:	
Total Employee Contribution:	

I hereby certify that the information provided above is true, accurate, and complete to the best of my knowledge, and that the employer contributions listed have been paid in accordance with company policy and applicable regulations.

Authorized Signatory Name & Title

Signature & Date