MONTHLY EMPLOYER HEALTH PREMIUM CONTRIBUTION REPORT

Employer Return Template

Employer Name:
Employer ID / Tax ID:
Corporate Address:
Reporting Month & Year:
Health Plan Provider:
Group Policy Number:

Contribution Summary

Category	Total Count / Amount
Total Active Eligible Employees	
Total Monthly Premium Due	
Total Employer Contribution Amount	
Total Employee Contribution Amount (Pre-Tax/Deducted)	
Net Remittance Amount	

Employee Contribution Breakdowns

No.	Employee ID	Employee Full Name	Coverage Level	Total Premium	Employer Share	Employee Share
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
			Totals:			

Prepared By (Authorized Representative):

Name:

Title:
Date:
Approved By (HR / Finance Manager):

Name:
Title:
Date: