STAFF HEALTH INSURANCE CONTRIBUTION RETURN

Employer Submission Template

EMPLOYER NAME:

EMPLOYER TIN / ID:

CONTACT PERSON:

EMAIL / PHONE:

REPORTING PERIOD:

INSURANCE PROVIDER:

POLICY NUMBER:

SUBMISSION DATE:

CONTRIBUTION SUMMARY			
Total Employees Active:		**Total Employer Contribution:**	
Total Premium Amount:		**Total Employee Contribution:**	

#	EMPLOYEE ID	EMPLOYEE NAME (LAST, FIRST)	COVERAGE PLAN / TIER	EMPLOYER SHARE	EMPLOYEE SHARE	TOTAL MONTHLY PREMIUM
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
Totals						

PREPARED BY (HR / PAYROLL REPRESENTATIVE)

Signature

Print Name:

Date:

AUTHORIZED APPROVAL (FINANCE / MANAGEMENT)

Signature

Print Name:

Date: