# EMPLOYER HEALTH INSURANCE CONTRIBUTION RETURN

Annual/Quarterly Report Form

## SECTION 1: EMPLOYER IDENTIFICATION

**Employer Name**

**Federal Employer Identification Number (FEIN)**

**Mailing Address**

**Reporting Period (Q1, Q2, Q3, Q4 or Annual)**

**Tax Year**

**Contact Person & Phone Number**

## SECTION 2: CONTRIBUTION SCHEDULE (BY EMPLOYEE/PLAN)

| Employee Name / ID | SSN (Last 4 digits) | Health Plan Type | Total Premium ($) | Employer Contribution ($) | Employee Contribution ($) |
|---|---|---|---|---|---|
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| | | **Totals:** | | | |

## SECTION 3: SUMMARY OF CONTRIBUTIONS

**1. Total Number of Eligible Employees**

**2. Total Number of Participating Employees**

**3. Employer Contribution Percentage (%)**

## SECTION 4: DECLARATION AND AUTHORIZATION

Under penalties of perjury, I declare 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. Declaration of preparer (other than employer) is based on all information of which preparer has any knowledge.

**Signature of Authorized Employer Officer**

**Date (MM/DD/YYYY)**

**Printed Name of Officer**

**Title of Officer**

Print Form