EMPLOYER HEALTH BENEFIT CONTRIBUTION DECLARATION

EMPLOYER / COMPANY NAME

EMPLOYER IDENTIFICATION NUMBER (EIN)

COMPANY ADDRESS

REPORTING PERIOD (MONTH/YEAR)

HEALTH INSURANCE PROVIDER

GROUP POLICY NUMBER

No.	Employee Name	Employee ID / SSN	Employer Contribution Amount	Employee Contribution Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
		Total Contribution:		

I hereby certify and declare under penalty of perjury that the employer health insurance contributions listed above represent accurate and true amounts paid on behalf of the eligible employees during the designated reporting period.

AUTHORIZED SIGNATURE

PRINTED NAME AND TITLE

DATE