

The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Division of Health Care Finance and Policy

Employee Health Insurance Responsibility Disclosure Form

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement.

Employer Name: _____ **FEIN:** _____
Employer D/B/A: _____
Employer Address: _____
City | State | ZIP Code: _____

Employer: Please report the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee. \$ _____

Employee First Name _____ **Middle Initial** _____
Employee Last Name _____ **Suffix (e.g., Sr., Jr.)** _____

Employee Social Security or Tax Identification Number
 [][][] - [][] - [][][][][]

Employees: please check the appropriate box for each question.

1. Were you offered employer subsidized health insurance? Yes No
 1a. If Yes, did you decline your employer subsidized health insurance? Yes No

2. Were you offered a "Section 125 Cafeteria Plan" to pay for health insurance? Yes No
 2a. If Yes, did you decline to use your employer's "Section 125 Cafeteria Plan" to pay for health insurance? Yes No

3. Do you have other health insurance? Yes No

Employee Affidavit

I hereby affirm, under penalties of perjury that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

Employee Signature

Date (MM/DD/YY)

____/____/____

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Division of Revenue as required by state regulation 114.5 CMR 18.00.