USA PAYROLL

Health Insurance Tracking Form

Please complete this form to report the cost of the tax-free medical coverage under an employer-sponsored group health plan for each employee (this is optional for employers in 2011). This information will be included in Box 12 on employee W-2's for informational purposes only. Sign & date the form and return it to your Payroll Specialist.

Date: _____

Client Number: _____ **Company Name:** _____

Tax Year: _____ **Payroll Specialist:** _____

Please check your Plan Type and indicate the amount or percentage of employer contributions for the plan:

☐ Single Plan _____ % _____ Amount

☐ 2 Person Plan _____ % _____ Amount

☐ Family No Spouse Plan _____ % _____ Amount

☐ Family EE Plus Child/Children Plan _____ % _____ Amount

Would you like the contribution amount shown on the employee check stubs? (check one) ☐ Yes ☐ No

The amounts provided below per employee are (check one):

☐ Per Pay Period Amounts ☐ Monthly Amounts ☐ Quarterly ☐ Annual Amounts

Employee Name:	Amount of Employer Contribution:

Client Signature: _____ Date: ___/____/____

For Internal Use:

Completed By: _____ Completion Date: _____ Scanned to Health Folder By: _____