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

Employee Health Insurance Responsibility Disclosure Form

2015

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. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. For information about affordable health insurance options, visit the Commonwealth Connector at < www.mahealthconnector.org >.

Employer

Employers: please complete this section. See reverse side for instructions.

Employer Name: TOWN OF MEDFIELD **FEIN:** 04-6001216

Employer D/B/A:

Employer Address: 459 Main Street

City | State | ZIP Code: Medfield, MA 02052

1. Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes [X] No [ ]
2. Did you offer employer sponsored health insurance to this employee? Yes [X] No [ ]
3. If you offered sponsored insurance to this employee, what is 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? (If did not offer sponsored insurance, leave blank.) $ 298.99

Employee

Employees: please complete this section. See reverse side for instructions.

Employee First Name **Middle Initial**

Employee Last Name **Suffix** (e.g., Sr., Jr.)

1. Did you accept your employer sponsored health insurance? Yes [ ] No [ ] None Offered [ ]
2. Did you agree to use your employer's "Section 125 Cafeteria Plan" to purchase health insurance? Yes [ ] No [ ] None Offered [ ]
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.

DHCFP-EHIRD10