Town of Holliston

Employee Health Insurance Responsibility Disclosure Form

You are completing this form because it has been determined that you are eligible to participate in the Town of Holliston's employer sponsored health insurance plan and/or have declined to participate in the Town'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.**

Under the Affordable Care Act, employees who are eligible to participate in an employer sponsored health insurance must complete this form annually.

EMPLOYER SECTION

Employer Name: Town of Holliston FEIN: 04-6001184
Employer Address: 703 Washington Street, PO Box 6737, Holliston, MA 01746

1. Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes ___ No ___
2. Did you offer employer sponsored health insurance to this employee? Yes ___ No ___
3. Date a "Section 125 Cafeteria Plan" and employee sponsored health insurance was offered: **04/18/17 for FY18**
4. 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? **FY18- Fallon Direct Care Benchmark $237.60**

EMPLOYEE SECTION

Please Print

Employee First Name _____ Middle Initial _____ Last Name_____

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 ___

****A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis****

3. Do you have other health insurance? Yes ___ No ___
4. Average number of hours worked per week? _____
5. Are you a paid elected official, on-call firefighter, or EMT? Yes ___ No ___

Employee Affidavit

I hereby affirm, under penalties of perjury, that all of 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, and that I may forfeit all or a portion of my Federal and Massachusetts personal tax exemption.

Employee Signature **Date**

_____ _____

4/2017