2025 Health Insurance Responsibility Disclosure Form

Part 1, Company Information

Legal Company Name	
DBA Name	
Federal ID Number	

Contact Information

Contact Name	
Phone Number	
Email Address	
Mailing Address	
City, State, Zip Code	

Part 2, Company's Insurance Profile

1. Does the employer offer group health insurance? ____Yes ____No
   (If answer is "No", please go to page 4 to sign document.)
2. What is the minimum number of scheduled hours per week that the employer requires an employee to work to be considered eligible for health plan benefits? _____
3. What is the time period (in months) that a new employee must work before he or she is eligible for health plan benefits? Value must be greater than or equal to 1. _____
4. Does employer determine employee eligibility for health plan benefits according to employment based categories for different groups of employees? ____Yes ____No
5. Does employer offer different health plan benefits/rates for health plan benefits according to employment based categories for different groups of employees? ____Yes ____No
6. Does employer offer health plan(s) which use Massachusetts Health Connector Employee Choice Models? ____Yes ____No

If you answer "No" to question 5, please go to Part 3.

Select the employment categories that the employer utilizes. (Select as many employment-based categories as necessary.)

Regular Full-time	Regular Part-time	Temporary Full-time
Temporary Part-time	Salaried	Hourly
Union	Non-Union	Management
Non-Management	Exempt	Non-Exempt
Wage Based	Intern	Other

If you checked off "Other" above, describe the employment-based category(ies) and indicate which specific health plan(s) the employees in each "Other" category have access to.

_____

_____

If applicable, describe how the employer defines each employment-based category and the employer's

eligibility requirements for health plan benefits according to each category.

_____

_____

Part 3, Union Information

1. Does the employer employ any union members who receive Group Health Insurance through a union rather than through the employer? ____Yes ____No
2. If applicable, list the unions from which the unionized employees receive health insurance.

   _____

Part 4, Plan Information

Open Enrollment Period Start Date	
Open Enrollment Period End Date	
Plan Year's (aka Rate Year) Start Date	
Plan Year's (aka Rate Year) End Date	

Only if necessary, use this space to report additional information not otherwise captured in this form that is necessary to explain the employer's group health insurance offerings and/or eligibility requirements.

_____

_____

_____

Health Plan 1 Profile

Name of the Insurance Plan	
Name of Health Insurer	
Name of Health Plan	
Plan Group Number(s)	

Indicate the employment-based categories that have access to this plan. (Select as many employment-based categories as necessary.)

Regular Full-time	Regular Part-time	Temporary Full-time
Temporary Part-time	Exempt	Non-Exempt
Salaried	Hourly	Other

Levels of Coverage

For each Level of Coverage offered by this plan, complete the following information. If not offered, enter N/A.

Coverage Offered	Plan's Total Monthly Cost	Employee's Monthly Contribution	In-Network Annual Deductibles	Annual Out of Pocket Max Expenses
Individual				
Employee Plus One				
Employee Plus Children				
Family				

Do the benefits provided under the health insurance plan satisfy the minimum creditable coverage requirements of 956 CMR 5.03(1)(a)? ____Yes ____No

Health Plan 1 Profile (Continued)

Does the employer offer its employees wellness credits that may reduce the employee contribution to the premium for this plan? ____Yes ____No

Enter the date on which the following costs and coverage information became or will become effective for this plan. _____

Health Plan 2 Profile

Name of the Insurance Plan	
Name of Health Insurer	
Name of Health Plan	
Plan Group Number(s)	

Indicate the employment-based categories that have access to this plan. (Select as many employment-based categories as necessary.)

Regular Full-time	Regular Part-time	Temporary Full-time
Temporary Part-time	Exempt	Non-Exempt
Salaried	Hourly	Other

Levels of Coverage

For each Level of Coverage offered by this plan, complete the following information. If not offered, enter N/A.

Coverage Offered	Plan Total Monthly Cost	Employee's Monthly Contribution	In-Network Annual Deductibles	Annual Out of Pocket Max Expenses
Individual				
Employee Plus One				
Employee Plus Children				
Family				

Do the benefits provided under the health insurance plan satisfy the minimum creditable coverage requirements of 956 CMR 5.03(1)(a)? ____Yes ____No

Does the employer offer its employees wellness credits that may reduce the employee contribution to the premium for this plan? ____Yes ____No

Enter the date on which the following costs and coverage information became or will become effective for this plan. _____

Attach additional copies of this page if the employer offers more than two health plans.

Number of additional pages attached. _____

The next page is the fee schedule and signature page.

2025 Health Insurance Responsibility Disclosure Fee Schedule

Forms Received Before December 10, 2025	
No Insurance Plan to report	$55.00
One Insurance Plan to report	$110.00
Additional Insurance Plans	$55.00 per plan
Forms Received After December 9, 2025 and Before December 13, 2025	
No Insurance Plan to report	$110.00
One Insurance Plan to report	$220.00
Additional Insurance Plans	$55.00 per plan
Forms Received After December 12, 2025	
No Insurance Plan to report	$165.00
One Insurance Plan to report	$330.00
Additional Insurance Plans	$55.00 per plan

Authorizations and Representations

Submission of this completed 2025 Health Insurance Responsibility Disclosure Form is a request for Vision Payroll Service to complete this form online through MassTaxConnect. Fee schedule is above. Your signature acknowledges the information provided is current and accurate. The Company represents that the individual signing this Agreement on its behalf has the authority to do so and to so legally bind the Company. Vision Payroll Service is directed to use this information in the performance of its services and Vision Payroll Service is hereby indemnified and held harmless for any liabilities caused by the use of this information.

_____ _____

Authorized Signature Name Printed

_____ _____

Title Date