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. 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 Upton **FEIN:** 046001330

Employer D/B/A: Town of Upton

Employer Address: 1Main Street Suite 1

City | State | ZIP Code: Upton, MA 01568

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. 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.) $ $241.19

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 Department of Revenue as required by state regulation 114.5 CMR 18.00.

Instructions

Employer Information

Employer Name
Employers must enter the company's legal name.

FEIN
The employer must enter the Federal Employer Identification Number.

D/B/A
The employer must enter the company's trade name "Doing Business As" here, if applicable.

Employer Address
The employer must enter the business address including city, state, and ZIP Code.

Question 1
The employer must indicate either Yes or No (check box).

Question 2
The employer must indicate either Yes or No (check box).

Question 3
The employer must 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, if the employer offers a sponsored health plan (i.e. the employer offers to pay for a portion of the premium).

Employee Information

Employee First Name
The employee or employer must enter the employee's first name.

Employee Last Name
The employee or employer must enter the employee's last name.

Question 1
The employee must indicate Yes, No, or None Offered if health insurance is not offered (check box).

Question 2
The employee must indicate Yes, No, or None Offered if a "Section 125 Cafeteria Plan" is not offered (check box).

Question 3
The employee must indicate Yes or No (check box).

Employee Signature
The employee must sign and date the Employee Health Insurance Responsibility Disclosure (HIRD) form.

Note to Employer Regarding Employee Signature
If the employee refuses to sign and date the form, the refusal should be noted in writing and signed by the authorized company representative (e.g., the owner, supervisor or manager, chief executive officer, etc.).

Alternate Versions of This Form

Employers may recreate their own version of the Employee Health Insurance Responsibility Disclosure (HIRD) form. However, all information must be included, with the same wording and order, and the sequence and numbering of the Questions must be exactly as it appears on the version provided by the Commonwealth of Massachusetts.