

*THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES*

DIVISION OF HEALTH CARE FINANCE AND POLICY

**Employee Health Insurance Responsibility Disclosure
2007**

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and have declined to participate in the employer's "Section 125" health insurance purchasing arrangement.

Employer Name: _____
Employer DBA: _____
Employer Address: _____
City/State/Zip: _____

Employee First Name

Employee MI

Employee Last Name

Employee Social Security or Tax Identification Number

Employees please check the appropriate box for each question.

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|--|-----|----|
| 1 Did you decline your Employer-Sponsored Health Plan? | Yes | No |
| 2 Did you decline to participate in your employer's "Section 125" health insurance purchasing arrangement? | Yes | No |
| 3 Do you have other health insurance? | Yes | No |

Employee Affidavit

I hereby swear (or 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 will be responsible for the full costs of all medical treatment, and that I may forfeit all or a portion of my Massachusetts personal tax exemption and other penalties pursuant to M.G.L c. 111M.

Employee Signature

Date (MM/DD/YY)

The employer must retain this document for three(3) years and make it available to the Division of Health Care Finance and Policy upon request as required by 114.5 CMR 18.00.

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