Fax completed form to 617-373-7610. **(Benefits Eligible)**

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy
Employee Health Insurance Responsibility Disclosure Form 2011

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.

Employer Name: **Northeastern University** **FEIN: 04-1679980**
Employer D/B/A: **Northeastern University**
Employer Address: **716 Columbus Ave, Suite 250**
City|State|ZIP Code: **Boston, MA 02120**

Employer: Please 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. $181.23

Employee First Name _____ **Middle Initial** _____

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

Employee Social Security or Tax Identification Number: _____

Employees: please check the appropriate box for each question.

1. Were you offered employer subsidized health insurance? *(Northeastern subsidizes by paying 70% of the premium cost and you pay 30%.)* Yes ☒ No ☐

1a. If Yes, did you decline your employer subsidized health insurance? Yes ☒ No ☐

2. Were you offered a "Section 125 Cafeteria Plan" to pay for health insurance? *(A Section 125 Plan means that premiums are paid with pre-tax dollars.)* Yes ☒ No ☐

2a. If Yes, did you decline to use your employer's "Section 125 Cafeteria Plan" to pay for health insurance? Yes ☒ No ☐

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.

Instructions

FAX COMPLETED FORM TO NU HRM BENEFITS Department at 617-373-7610.

EMPLOYER
Employers must complete all relevant fields.
Please 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.

Abbreviations

FEIN
Federal Employer Identification Number

D/B/A
Doing Business As, if applicable

EMPLOYEE INFORMATION

Employee First/Last Name & Middle Initial
The employee or employer must enter the employee's first name, last name and middle initial here.

Employee Social Security or Tax Identification Number
The employee or employer must enter the employee's Social Security or Tax Identification number here.

Questions 1 and 1a (Check Boxes)
The employee must check either Yes or No. This can not be left unchecked nor can both boxes be checked. If the answer to Question 1 is Yes, then 1a must also be checked Yes or No. If the answer to Question 1 is No, then Question 1a should be left unchecked.

Questions 2 and 2a (Check Boxes)
The employee must check either Yes or No. This can not be left unchecked nor can both boxes be checked. If the answer to Question 2 is Yes, then 2a must also be checked Yes or No. If the answer to Question 2 is No, then Question 2a should be left unchecked.

Questions 3 (Check Box)
The employee must check either Yes or No. This can not be left unchecked nor can both boxes be checked.

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.