

Fringe Benefits for Health Insurance - 2015

Client Name: _____ Client #: _____

Shareholder/Employee Name: _____ SSN: _____ - _____ - _____

(NOTE: Please complete a separate form for each Shareholder or Employee if applicable for more than one)

1. Did you provide health insurance benefits to a 2% or greater corporate shareholder? Yes No

Shareholder health insurance premium (including long term care) paid per month: \$ _____

How many monthly payments will be paid this year? _____

2. Did you contribute to a health savings account for any shareholder or employee? Yes No

(IF YOU PROVIDE AN HSA TO YOUR EMPLOYEES, YOU MUST COMPLETE THIS FOR ALL EMPLOYEES)

Amount of corporate contribution to HSA: \$ _____

3. Did you provide group-term life insurance benefits of over \$50,000 to any shareholder or employee? Yes No

Face amount of term life insurance policy: \$ _____

Signature: _____ Date: _____