Reporting on Employer Premium Contribution
2024 Information Request Form

Employer Name: _____

Doing Business As (if applicable): _____

Average % of employer paid contributions to only Independent Health medical plan premiums in calendar year 1/1/2024 – 12/31/2024): _____

For example, if your group paid $10,000 to Independent Health towards medical plan premiums from January 1, 2024 – December 31, 2024, and your group funded $5,000 of that on behalf of your employees, please report 50%.

☐ **If there is no employer contribution, please check the box.**

ATTESTATION FOR EMPLOYER/BROKER: I completed this form as a representative of the above-named employer group. I am duly authorized to provide this information to Independent Health. I attest that the information I provide is correct, accurate, and complete to the best of my knowledge. If there are errors or omissions in the information I provide, Independent Health shall not be held legally responsible for such errors of omissions, or the accuracy or inaccuracy of any reports Independent Health prepares for the above-named employer under the above-referenced law or regulations. I agree and accept these terms and conditions when I sign below and send Independent Health this completed form.

EMPLOYER

By: _____
Signature

_____
Employer Representative's Name

_____ Date: _____
Employer Representative's Title

OR

BROKER

By: _____
Signature

_____
Broker's Name

_____ Date: _____
Broker's Title

Please return this form to Sales.Administration@independenthealth.com or fax it to 716-631-8554. If you have any questions, please contact your account manager.