

Employer Affidavit for Reimbursement of Individual/Family Health Plan

Please complete the information below if you are reimbursing an employee for all or a portion of the premium for an Individual/Family Health Plan.

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| Name of Employer / Business: | | |
| Employer Address: | City, State: | Zip Code: |
| Employee Information | | |
| Last Name: | | First Name: |
| Date of Birth: / / | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number: |
| Home Address: | City, State: | Zip Code: |
| Affidavit | | |
| <p>The undersigned officer or principal of the employer identified above certifies that:</p> <ol style="list-style-type: none"> 1. The employer is a small employer as defined in § 10-16-102(40), C.R.S., with fifty (50) or fewer eligible employees; 2. The employer has not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit. 3. A false certification may cause the rescission of the employee's individual insurance policy and subject the employer to penalties for perjury and liability to the employee | | |
| Signature: | | Date: |
| Printed Name: | | Title: |