

Employee Number

NAME (Last Name, First Name, MI)

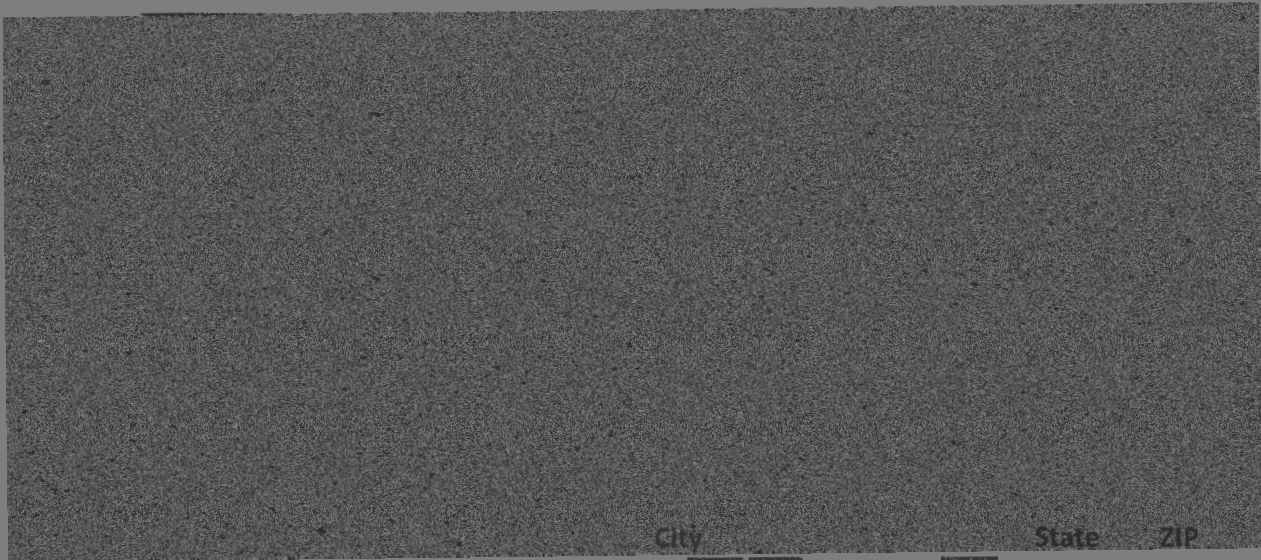
Mailing Address

Street Address/Box/Apt.

City

State

ZIP



City

State

ZIP

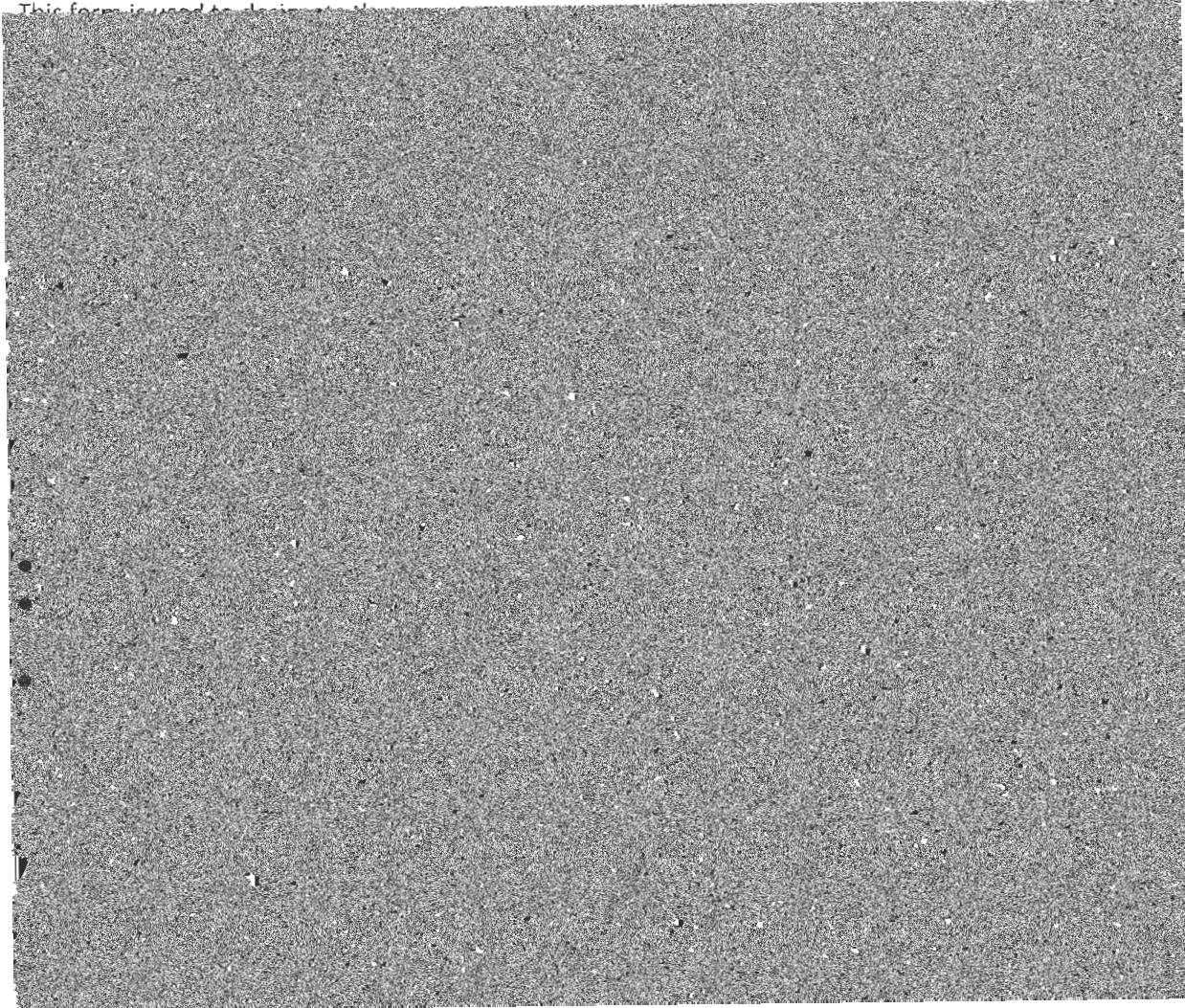
EMPLOYEE SIGNATURE

DATE

## Employee Instructions

### **Purpose of this Form**

This form is used to claim a tax credit for the employer's contribution to the employee's health insurance plan.



### **Submitting the Form**