



Cobra Subsidy Credit Form

Company Name _____

Client/Co # _____ - _____

Federal ID# _____ - _____

4/13/2009

Dear Client,

Please list the employees and the Premium Amounts for the month of _____ Year _____.

Employee Names	ER Premium (required)	EE Premium (optional)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Employee Names	ER Premium (required)	EE Premium (optional)
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
Total of Listed Premium Amount(s)		

In order to recoup your portion (65%) of the health insurance premiums made on behalf of your previous employee(s), Payville USA will keep accurate records on the above information so that we may properly reduce your next FED/FICA deposit(s).

However, to qualify for this reduction, the following items **must have** occurred:

- The employer has collected corresponding premium amounts (35%) from the listed employees above.
- The employer has paid the insurance carrier the full (100%) employee premium amounts.
- The employees listed qualify for the subsidiary due to termination (not voluntary resignation).
- The employer has appropriate documentation to substantiate what has been declared above.
- The employer understands that Payville USA is not acting as a COBRA administrator.
- Payville USA is not tracking an employee's eligibility, nor their duration in this subsidy program.
- The employer understands that Payville USA will apply the above FED/FICA credit with your **next** normal payroll.
- If your subsidy credit is greater than your next FED/FICA tax liability, the excess will be carried forward to future deposit(s).

Authorized Agent Name

Title

Authorized Agent Signature

Date

*** FOR OFFICE USE ONLY ***					
P/R Data Adjusted:	_____	_____	Tax Credit Applied:	_____	_____
	Date Payroll Adjusted	(Initials)		Date Tax Credit Applied	(Initials)
Finance Received	_____	_____	Tax Account Recon'ed	_____	_____
	Finance Dept Received On	(Initials)		Date Tax Acc't Recon'ed	(Initials)