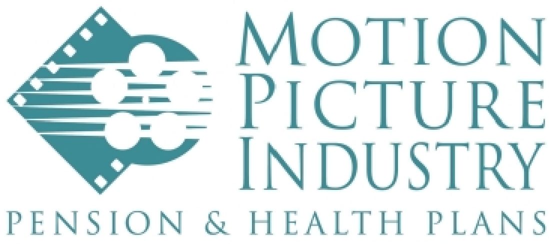

Plan office use only:			
Emp #		Report #	
TID#		Batch #	

REPORT OF CONTRIBUTIONS

Rate Group 30
Active Health Only

(A) Employer: ______________________ Employer #: ______________

(B) Address: ____

______________________ Check box if address changed: ☐

Phone: ______________ Fax: ______________ E-Mail: ______________

(C) # Weeks: __________ From: ______________ To: ______________

(D) Client Co.: ______________________ Client #: ______________

(E) Prod. Title: ______________________ Prod. ID # ______________

IF YOU HAVE NO COVERED EMPLOYEES FOR THIS PERIOD, CHECK THIS BOX ☐

See reverse side for additional information

ACTIVE HEALTH CONTRIBUTION RATE (Effective July 30, 2006):

Active Medical:	$1.4580	________		________
Active Dental:	$0.1870	________		________
Active Vision:	$0.0500	________		________
	TOTAL HOURS:	________	**@ $1.6950**	$ ________

TOTAL AMOUNT DUE:	$ ________
Less amount previously remitted:	$ ( )
TOTAL AMOUNT DUE WITH THIS REPORT:	$ ________

Note: Please submit ONE contribution check.
Make check payable to: **M.P.I.P.H.P.**

Date: ______________ Signed by: ______________ Title: ______________

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