



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

ACTIVE HEALTH CONTRIBUTION RATE (Effective August 01, 2010):

Active Medical:	\$2.3080	_____	_____
Active Dental:	\$0.1870	_____	_____
Active Vision:	\$0.0500	_____	_____
TOTAL HOURS:		_____	@ \$2.5450 \$ _____
TOTAL AMOUNT DUE:			\$ _____
Less amount previously remitted:			\$ () _____
<u>TOTAL AMOUNT DUE WITH THIS REPORT:</u>			\$ _____

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

Date: _____ Signed by: _____ Title: _____