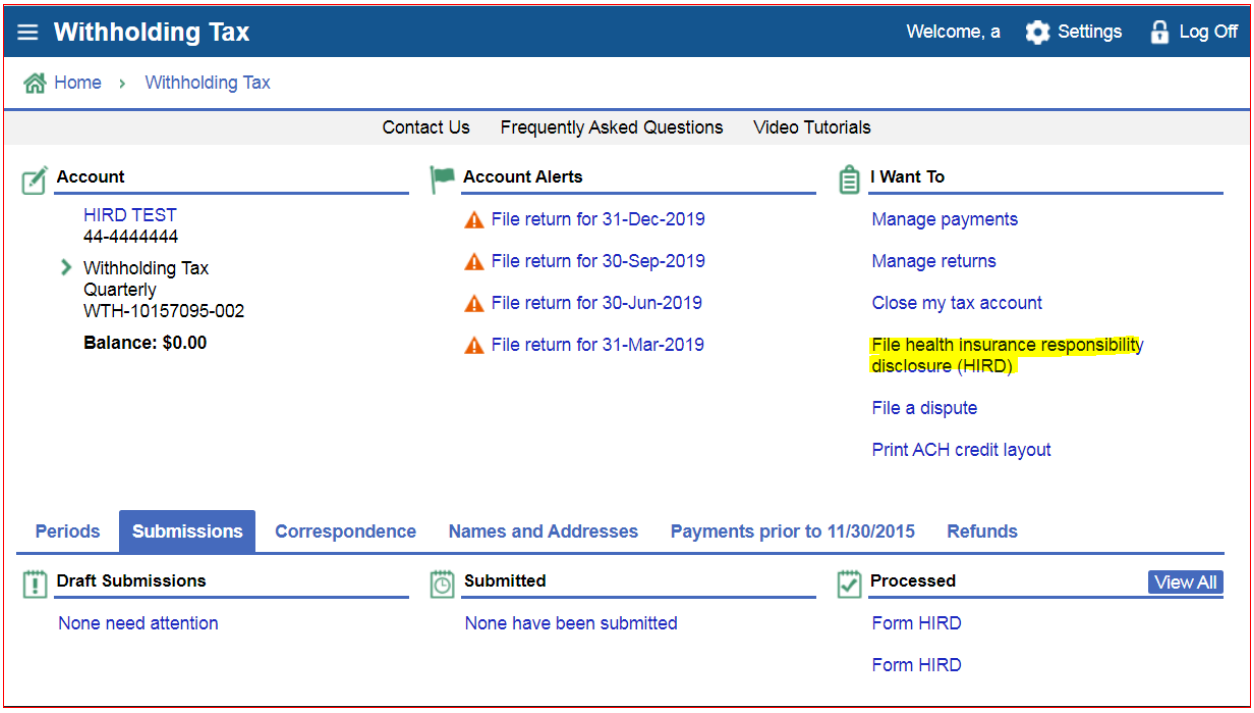
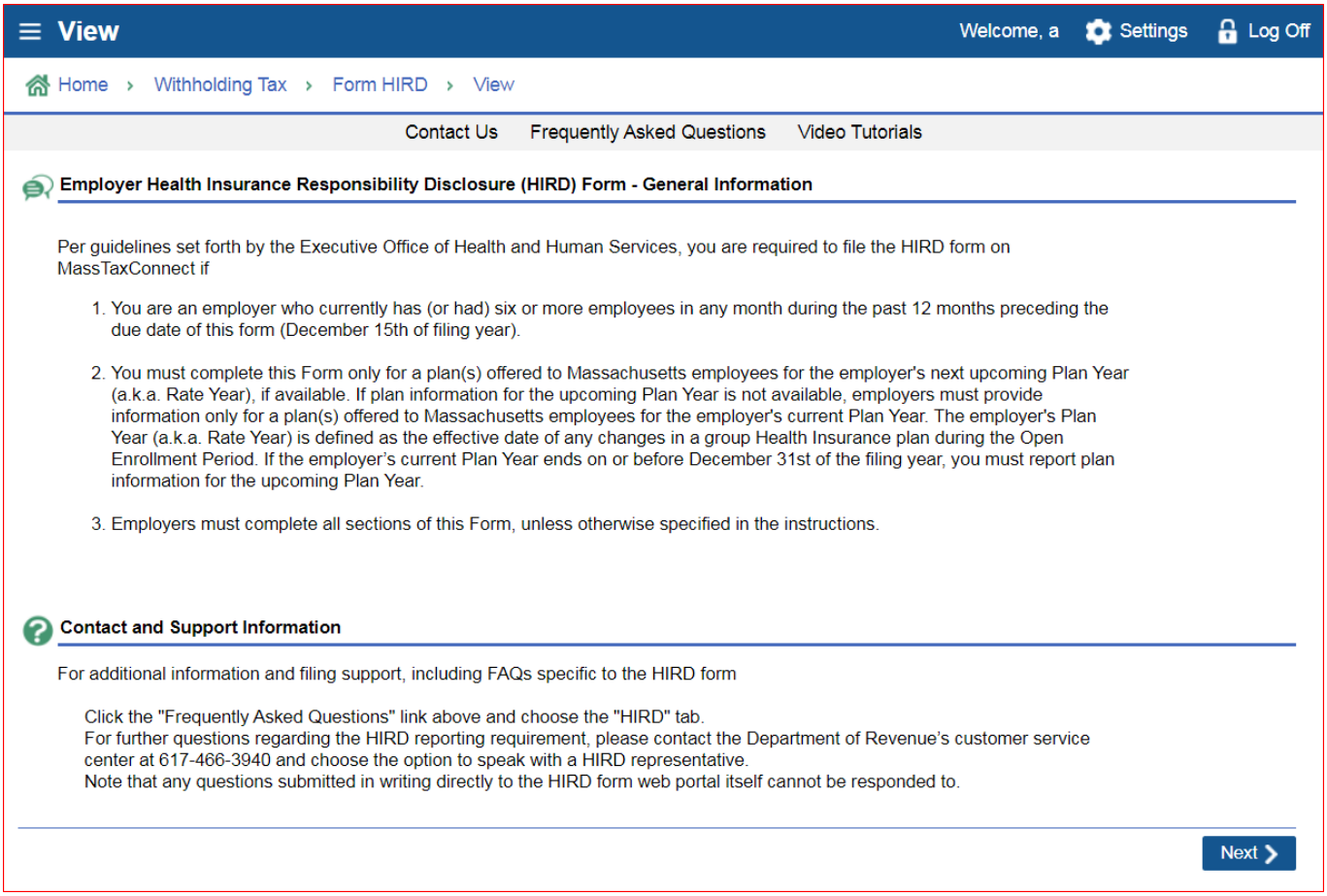

Withholding Tax
Welcome, a
Settings
Log Off
Home
Withholding Tax
Contact Us
Frequently Asked Questions
Video Tutorials
Account
HIRD TEST
44-4444444
Withholding Tax
Quarterly
WTH-10157095-002
Balance: $0.00
Account Alerts
File return for 31-Dec-2019
File return for 30-Sep-2019
File return for 30-Jun-2019
File return for 31-Mar-2019
I Want To
Manage payments
Manage returns
Close my tax account
File health insurance responsibility disclosure (HIRD)
File a dispute
Print ACH credit layout
Periods
Submissions
Correspondence
Names and Addresses
Payments prior to 11/30/2015
Refunds
Draft Submissions
None need attention
Submitted
None have been submitted
Processed
View All
Form HIRD
Form HIRD


View
Welcome, a
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Withholding Tax
Form HIRD
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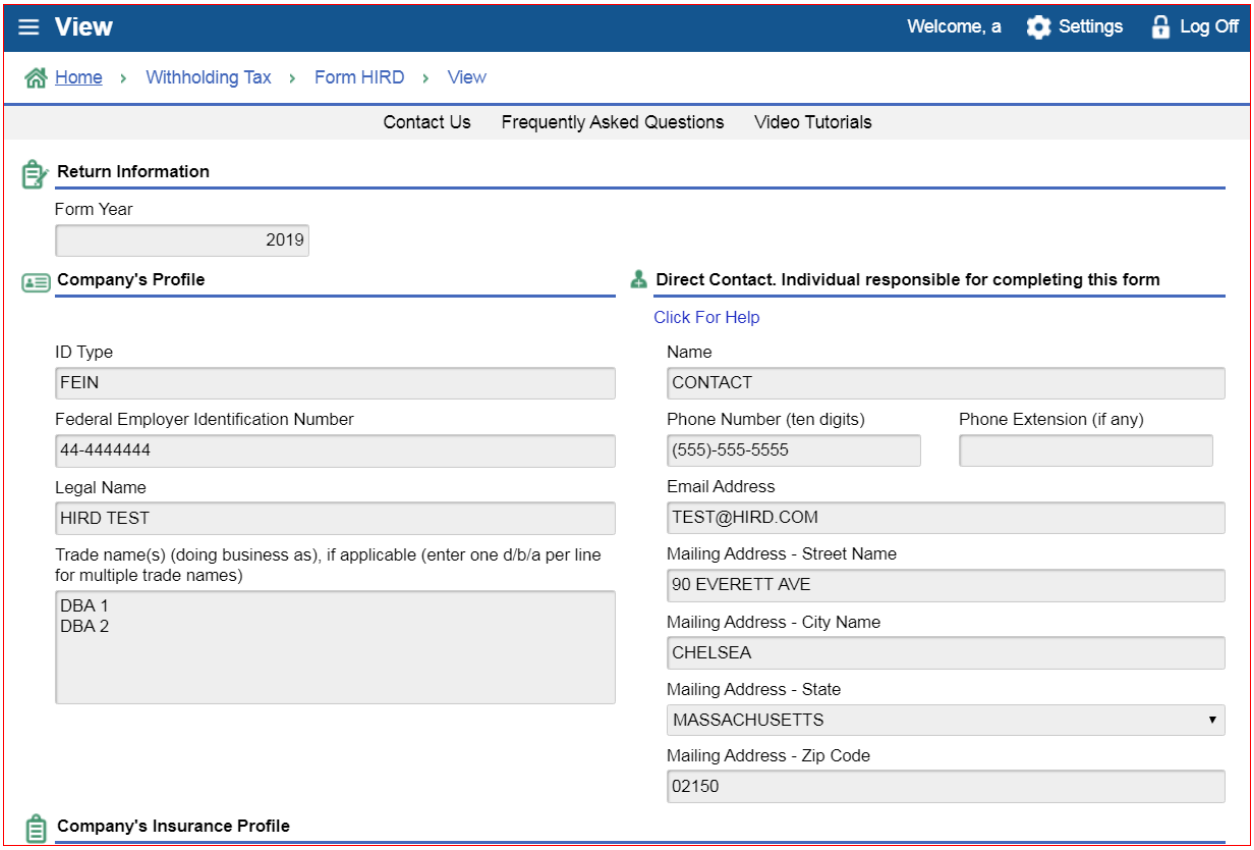
Employer Health Insurance Responsibility Disclosure (HIRD) Form - General Information
Per guidelines set forth by the Executive Office of Health and Human Services, you are required to file the HIRD form on MassTaxConnect if
1. You are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15th of filing year).
2. You must complete this Form only for a plan(s) offered to Massachusetts employees for the employer's next upcoming Plan Year (a.k.a. Rate Year), if available. If plan information for the upcoming Plan Year is not available, employers must provide information only for a plan(s) offered to Massachusetts employees for the employer's current Plan Year. The employer's Plan Year (a.k.a. Rate Year) is defined as the effective date of any changes in a group Health Insurance plan during the Open Enrollment Period. If the employer's current Plan Year ends on or before December 31st of the filing year, you must report plan information for the upcoming Plan Year.
3. Employers must complete all sections of this Form, unless otherwise specified in the instructions.
Contact and Support Information
For additional information and filing support, including FAQs specific to the HIRD form
Click the "Frequently Asked Questions" link above and choose the "HIRD" tab.
For further questions regarding the HIRD reporting requirement, please contact the Department of Revenue's customer service center at 617-466-3940 and choose the option to speak with a HIRD representative.
Note that any questions submitted in writing directly to the HIRD form web portal itself cannot be responded to.
Next


View
Welcome, a
Settings
Log Off
Home
Withholding Tax
Form HIRD
View
Contact Us
Frequently Asked Questions
Video Tutorials
Return Information
Form Year
2019
Company's Profile
ID Type
FEIN
Federal Employer Identification Number
44-4444444
Legal Name
HIRD TEST
Trade name(s) (doing business as), if applicable (enter one d/b/a per line for multiple trade names)
DBA 1
DBA 2
Direct Contact. Individual responsible for completing this form
Click For Help
Name
CONTACT
Phone Number (ten digits)
(555)-555-5555
Phone Extension (if any)
Email Address
TEST@HIRD.COM
Mailing Address - Street Name
90 EVERETT AVE
Mailing Address - City Name
CHELSEA
Mailing Address - State
MASSACHUSETTS
Mailing Address - Zip Code
02150
Company's Insurance Profile

Company's Insurance Profile

Does the employer offer group health insurance? Click for help

No | **Yes**

What is the minimum number of scheduled hours per week that the employer requires an employee to work to be considered eligible for health plan benefits? Click for help

40.00

What is the time period (in months) that a new employee must work before he or she is eligible for health plan benefits? Value must be greater than or equal to 1, and less than or equal to 24. Click for help

6

Does employer determine employee eligibility for health plan benefits according to employment based categories for different groups of employees? Click for help

No | **Yes**

Does employer offer different health plan benefits / rates for health plan benefits according to employment based categories for different groups of employees? Click for help

No | **Yes**

Select the employment-based categories that the employer utilizes. (Select as many employment-based categories as necessary). Click for help

Regular Full-time: No / **Yes**	Regular Part-time: No / **Yes**	Management: No / **Yes**	Non-Management: No / **Yes**
Temporary Full-time: No / **Yes**	Temporary Part-time: No / **Yes**	Exempt: No / **Yes**	Non-Exempt: No / **Yes**
Salaried: No / **Yes**	Hourly: No / **Yes**	Wage Based: No / **Yes**	Intern: No / **Yes**
Union: No / **Yes**	Non-Union: No / **Yes**	Other: No / **Yes**	

If the employer answered Yes to “other”, describe the “other“ employment-based category(ies) and indicate which specific health plan(s) the employees in each “other” category have access to.

test 1

test 1

If applicable, describe how the employer defines each employment-based category and the employer's eligibility requirements for health plan benefits according to each category. Click for help

test 2

Does the employer employ any union members who receive Group Health Insurance through a union rather than through the employer? Click for help

No **Yes**

If applicable, list the unions from which the employer's unionized employees receive group health insurance. Click for help

test 3

Open enrollment period: Start Date Click for help

01-May-2020

Plan year's (a.k.a rate year) Start date Click for help

01-Jul-2020

Open enrollment period: End Date Click for help

31-May-2020

Plan year's (a.k.a rate year) End date Click for help

01-Jun-2021

Only if necessary, use this space to report additional information not otherwise captured in this form that is necessary to explain the employer's group health insurance offerings and/or eligibility requirements. Click for help

test 4

Previous Next

HIRD Plans | PLAN

PLAN

Plan's Profile

Name of the Health Insurer. Click for help

INSURER

Name of the Health Plan. (Only report comprehensive health insurance plans; do not report dental or vision plans) Click for help

PLAN

Plan group number(s)

A123
B456

Do the benefits provided under the health insurance plan satisfy the minimum creditable coverage requirements of 956 CMR 5.03(1)(a)? Click for help

No | Unknown | **Yes**

Most health plans offered in Massachusetts satisfy the Minimum Creditable Coverage requirements.

Does the employer offer its employees wellness credits that may reduce the employee contribution to the premium for this plan? Click for help

No | **Yes**

Enter the date on which the following costs and coverage information became or will become effective for this plan. Click for help

01-Jul-2020

Indicate the employment-based categories that have access to this plan (Select as many employment-based categories as necessary). Click for help

Regular Full-time

No | **Yes**

Regular Part-time

No | **Yes**

Temporary Full-time

No | **Yes**

Temporary Part-time

No | **Yes**

Management

No | **Yes**

Non-Management

No | **Yes**

Management

No | **Yes**

Non-Management

No | **Yes**

Exempt

No | **Yes**

Non-Exempt

No | **Yes**

Salaried

No | **Yes**

Hourly

No | **Yes**

Union

No | **Yes**

Non-Union

No | **Yes**

Wage Based

No | **Yes**

Intern

No | **Yes**

Other

No | **Yes**

Levels Of Coverage

Which levels of coverage are offered by this plan? Click for help

Individual

No | **Yes**

Employee Plus One

No | **Yes**

Employee Plus Children

No | **Yes**

Family

No | **Yes**

For each Level of Coverage offered by this plan (i.e., individual, employee plus one, employee plus child/children, family), complete the following information.

The value of the Plan's Total Monthly Cost field must be equal to the sum of the Employee's Monthly Contribution and Employer's Monthly Contribution fields.

The values entered in these fields should not factor in potential reductions from any wellness credits, Health Reimbursement Arrangements, Flexible Spending Arrangements, or Health Savings Accounts.

Employee's Monthly Contribution | **Employer's Monthly Contribution** | **Plan's Total Monthly Costs**

Employee's Monthly Contribution

Click for help

Individual: 1,000.00

Employee Plus One: 2,000.00

Employee Plus Children: 3,000.00

Family: 4,000.00

Employer's Monthly Contribution

Click for help

Individual: 1,500.00

Employee Plus One: 2,500.00

Employee Plus Children: 3,500.00

Family: 4,500.00

Plan's Total Monthly Costs

Click for help

Individual: 2,500.00

Employee Plus One: 4,500.00

Employee Plus Children: 6,500.00

Family: 8,500.00

In-Network Annual Deductibles

Click for help

Individual: 1,000.00

Employee Plus One: 3,000.00

Employee Plus Children: 5,000.00

Family: 7,000.00

Annual Out Of Pocket Max Expenses

Click for help

Individual: 9,000.00

Employee Plus One: 11,000.00

Employee Plus Children: 13,000.00

Family: 15,000.00

Previous Next

Return Summary

Confirm this information is accurate and then use the ***Submit*** button to submit your return. If you notice something was entered incorrectly, use the ***Previous*** button and correct it before submitting.

Summary: Employer Information

Company's Profile And Direct Contact :

[1] Legal Name: HIRD TEST
[2] Trade name doing business as if applicable: DBA 1
DBA 2
[3] Federal Employer Identification Number: 44-4444444
[4] Direct Contact Name: CONTACT
[5] Direct Contact Phone number: 5555555555
[6] Direct Contact Email address: TEST@HIRD.COM
[7] Mailing address Street Name: 90 EVERETT AVE
[8] Mailing address City Name: CHELSEA
[9] Mailing address State: MA
[10] Mailing address Zip Code: 02150

Company's Insurance Profile:

[11] Employer offer group health insurance: Yes
[12] Qualifying minimum work hours per week: 40
[13] Qualifying time period in months: 6
[14] Has employment-based categories for health plan benefits: Yes
[15] Has employment-based categories for different health plan benefits rates: Yes
[16] Employment based categories: test 2
[17] Has union members: Yes
[18] List of the unions: test 3
[19] Open enrollment period start: 5/1/2020
[20] Open enrollment period end date: 5/31/2020
[21] Plan year start date: 7/1/2020
[22] Plan year end date: 6/1/2021

Summary: Insurance Plans Reported

Plan Number	Plan Name	Group Number	Effect. Date
1	PLAN	A123 B456	01-Jul-2020

Declarations: By clicking the Submit button:

☑ **I understand that the HIRD form is considered final and complete once submitted. If you later realize you made a mistake, you may amend your electronic submission by logging in to your MTC withholding account and selecting the "Amend health insurance responsibility disclosure" hyperlink under the 'I Want To' section. You may only submit one amended HIRD form per day.**

I declare under the penalties of perjury that I examined the information that I am submitting and it is, to the best of my knowledge and belief, true and complete.

Save and Close | Cancel | Previous | Submit

Confirmation

Welcome, a | Settings | Log Off

Home › Withholding Tax › Health Information Responsibility Disclosure › Confirmation

Contact Us | Frequently Asked Questions | Video Tutorials

Enter Information › Review & Submit › **Complete**

Health Information Responsibility Disclosure - Submit Summary

Confirmation Number: 0-887-717-888
Saved Date and Time: 11/14/2019 2:17:20 PM

Taxpayer Name: HIRD TEST
FEIN: 44-4444444

Your *Health Information Responsibility Disclosure* has been submitted. **Please print this page by clicking the *Print* button.**

View Your Submitted Submission
This submission is available to be viewed at any time. From the home page, select the **Submissions** tab. The *Submitted* column displays a list of recently saved submissions or you can click the **View All** button and select the **Submitted** tab to view all submitted submissions by confirmation number. The form submission date is the date that the form is considered to be filed.

Contact Us
If you need further assistance, please contact the Department of Revenue at or toll-free in Massachusetts at (800) 392-6089. Business hours are 8:30AM to 4:30PM Monday - Friday.

OK | Print Confirmation