Form HIRD

Withholding Tax

WTH-20913601-002

TEST HIRD

Submitted

Confirmation #

1-976-507-840

Submitted 15-Mar-2023 12:17:48 PM by JANE JANE

› Delete

Form HIRD

Requirements for filing Form HIRD — HIRD Employer Details — HIRD Plans — Return Summary

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 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 an HIRD representative. Note that any questions submitted in writing directly to the HIRD form web portal itself cannot be responded to.

‹ Previous Next ›

Form HIRD

Withholding Tax

WTH-20913601-002

TEST HIRD

Submitted

Confirmation #

1-976-507-840

Submitted 15-Mar-2023 12:17:48 PM by JANE JANE

› Delete

Form HIRD

Requirements for filing Form HIRD | HIRD Employer Details | HIRD Plans | Return Summary

Return Information

Form Year	2022

Company's Profile

ID Type	FEIN
Federal Employer Identification Number	01-1111111
Legal Name	TEST HIRD
Trade name(s) (doing business as), if applicable (enter one DBA per line for multiple trade names)	DBA 1 DBA 2

Direct Contact - Individual Responsible for Completing This Form

Click For Help

Name	CONTACT NAME
Phone Number	(555) 555-5555
Phone Extension	
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

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
Does employer offer health plan(s) which use Massachusetts Health Connector Employee Choice Models? 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
Temporary Full-time	No	Yes
Salaried	No	Yes
Union	No	Yes
Regular Part-time	No	Yes
Temporary Part-time	No	Yes
Hourly	No	Yes
Non-Union	No	Yes
Management	No	Yes
Exempt	No	Yes
Wage Based	No	Yes
Other	No	Yes

Non-Management	No	Yes
Non-Exempt	No	Yes
Intern	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

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 1

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 2

Open enrollment period: Start Date Click for help	01-Dec-2022
Open enrollment period: End Date Click for help	31-Dec-2022
Plan year's (a.k.a rate year) Start date Click for help	01-Jan-2023
Plan year's (a.k.a rate year) End date Click for help	31-Dec-2023

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 3

Form HIRD

Withholding Tax

WTH-20913601-002

TEST HIRD

Submitted

Confirmation #

1-976-507-840

Submitted 15-Mar-2023 12:17:48 PM by JANE JANE

› Delete

Form HIRD

Requirements for filing Form HIRD ✓ — HIRD Employer Details ✓ — HIRD Plans ✓ — Return Summary ✓

HIRD Plans | **PLAN NAME**

PLAN NAME

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 NAME
Plan group number(s) Click for help	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-Jan-2023	

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
Temporary Full-time	No	Yes
Salaried	No	Yes
Union	No	Yes
Regular Part-time	No	Yes
Temporary Part-time	No	Yes
Hourly	No	Yes
Non-Union	No	Yes
Management	No	Yes
Exempt	No	Yes
Wage Based	No	Yes

Other	No	Yes
Non-Management	No	Yes
Non-Exempt	No	Yes
Intern	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

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	1,000.00
Employee Plus One	2,000.00
Employee Plus Children	3,000.00
Family	4,000.00

Plan's Total Monthly Costs

Click for help

Individual	2,000.00
Employee Plus One	4,000.00
Employee Plus Children	6,000.00
Family	8,000.00

In-Network Annual Deductibles

Click for help

Individual	1,000.00
Employee Plus One	2,000.00
Employee Plus Children	3,000.00
Family	4,000.00

Annual Out-of-Pocket Max Expenses

Click for help

Individual	9,000.00
Employee Plus One	10,000.00
Employee Plus Children	11,000.00
Family	12,000.00

Form HIRD

Withholding Tax

WTH-20913601-002

TEST HIRD

Submitted

Confirmation #

1-976-507-840

Submitted 15-Mar-2023 12:17:48 PM by JANE JANE

› Delete

Form HIRD

Requirements for filing Form HIRD ✓ — HIRD Employer Details ✓ — HIRD Plans ✓ — Return Summary ✓

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: TEST HIRD
[2] Trade name doing business as if applicable: DBA 1
DBA 2
[3] Federal Employer Identification Number: 01-1111111
[4] Direct Contact Name: CONTACT NAME
[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] Has plans which use Mass Health Connector Employee Choice Models: No
[17] Employment based categories: TEST 1
[18] Has union members: Yes
[19] List of the unions: TEST 2
[20] Open enrollment period start: 12/1/2022
[21] Open enrollment period end date: 12/31/2022
[22] Plan year start date: 1/1/2023
[23] Plan year end date: 12/31/2023

Summary: Insurance Plans Reported

Plan Number	Plan Name	Group Number	Effect. Date
1	PLAN NAME	A123 B456	01-Jan-2023

Confirmation

I understand that the HIRD form is considered final and complete once submitted. If I later realize I made a mistake, I may amend my electronic submission by logging into my MTC withholding account and selecting the "Amend a Health Insurance Responsibility Disclosure" hyperlink. I may only submit one amended HIRD form per day. ☑

< TEST HIRD

Form HIRD - Confirmation

- **Confirmation Number:** 1-976-507-840
- **Saved Date and Time:** 3/15/2023 12:17:48 PM
- **Taxpayer Name:** TEST HIRD
- **FEIN:** 01-1111111

Your *Form HIRD* 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 Monday through Friday, 9:00 a.m. to 4:00 p.m.

OK Print Confirmation