Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547
Phone: (802) 828-2551

Do not return this form to the Vermont Department of Taxes. You must retain this form for your records for three years.

VT Form HC-1

HEALTH CARE CONTRIBUTIONS WORKSHEET

Employer FEIN	Quarter / Year

Uncovered Employee Count:

Did you have 5 or more full-time equivalent (FTE) employees who were all age 18 and older in the previous quarter? . . . . . ☐ Yes ☐ No

- If you answered **NO**, check this box ☐ to certify no Health Care Fund Contributions will be due for this quarter.
- If you answered **YES**, complete Section 1 **or** 2 below (not both) depending on the health care coverage offered by your company.

Note: For Sections 1 and 2, do not report more than 520 hours for any individual employee, no matter how many actual hours the employee worked during the calendar quarter.

Section 1: Complete this if you **do not** offer to pay any part of the cost of health care coverage for **any** of your employees.

Enter the total number of hours worked by **all** employees you employed during the reporting quarter and continue to "Calculations Section," Line A . . . . . _____

Section 1: Total hours of uncovered employees

Section 2: Complete this if you **do** offer to pay part or all of the cost of health care coverage for **any** of your employees.

Enter the total number of hours worked by all employees in each of the following two categories:

1. Employees who are offered and eligible for coverage but choose **not** to accept the coverage and have no other health care coverage **or** have Medicaid **or** who are full-time employees and have health care coverage as individuals through the Vermont Health Benefit Exchange. . . . _____

Section 2, Line 1: Hours worked by employees offered coverage but did not accept.

2. Employees who are **not** eligible for the health care coverage offered to any other employees. You may exclude hours worked by a seasonal or part-time employee **as long as** you offer health care coverage to all regular, full-time employees, **and** the employee is covered by a plan other than Medicaid.. . . . . _____

Section 2, Line 2: Hours worked by employees not offered coverage.

Section 3: Calculations Section

A. Enter the total hours worked by all employees entered in Section 1 **or** the total of Lines 1 and 2 in Section 2. ***NOTE:*** *If the total is a partial hour, round down to the nearest hour.* **A.** _____

B. Divide the number of hours on Line A by 520. This is your **unadjusted** FTE count. ***NOTE:*** *Round down to the nearest whole number.* . . . . . **B.** 0

C. Number of exempted FTEs. . . . . **C.** 4

D. Subtract Line C from Line B. This is your **adjusted** and reportable FTE count. Enter this amount on Form WHT-436, Line 6. If equal to or less than zero, report -0-. . . . . **D.** 0

E. Multiply Line D by the appropriate amount shown in the table below. **This is your quarterly Health Care Contribution.** Enter this amount on Form WHT-436, Line 7, even if -0-. . . . . **E.** _____

HCC Premium per FTE Exemption (Line E)

Quarter Ending Date	HCC Premium	
03/31/2017 - 12/31/2017	$158.77	Use this HCC Premium amount for the calculation on Line E above.
03/31/2018 - 12/31/2018	$163.20	
03/31/2019 - 12/31/2019	$168.10	