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 "Section 3: 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 7. 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 8, even if -0-. . . . . **E.** _____

HCC Premium per FTE Exemption (Line E)		
Quarter Ending Date	HCC Premium	Use this HCC Premium amount for the calculation on Line E above.
03/31/2019 - 12/31/2019	$167.02	
03/31/2020 - 12/31/2020	$184.42	
03/31/2021 - 12/31/2021	$186.56	