

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
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**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. \_\_\_\_\_
- 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. \_\_\_\_\_
- 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	



VT Form <b style="font-size: 1.2em;">WHT-436</b>	<b style="font-size: 1.1em;">QUARTERLY WITHHOLDING                  RECONCILIATION and                  HEALTH CARE CONTRIBUTION</b>
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Business Name			Federal ID Number		
Address			Vermont Account ID		
City	State	ZIP Code	<b>For Department Use Only</b>		
Foreign Country (if not United States)					
Reporting Period - Check only ONE. If due date falls on a weekend or holiday, return is due the next business day.				Year being reported (YYYY)	
<input type="checkbox"/> JAN - MAR (due Apr. 25)	<input type="checkbox"/> APR - JUN (due Jul. 25)	<input type="checkbox"/> JUL - SEP (due Oct. 25)	<input type="checkbox"/> OCT - DEC (due Jan. 25)		

- A.** Number of full-time employees as of the last day of this quarter... **A.** \_\_\_\_\_
- B.** Number of part-time employees as of the last day of this quarter... **B.** \_\_\_\_\_
- C.** Check here if this is an AMENDED return. .... **C.**

**PART I WAGE WITHHOLDING**

- 1.** Total Vermont wages paid this quarter ..... **1.** \_\_\_\_\_
- 2.** Total Vermont tax withheld from wages this quarter..... **2.** \_\_\_\_\_

**PART II NONWAGE WITHHOLDING**

- 3.** Total nonwage payments subject to withholding  
 this quarter ..... **3.** \_\_\_\_\_
- 4.** Total Vermont tax withheld from nonwage payments this quarter ..... **4.** \_\_\_\_\_
- 5. Total Vermont tax withheld this quarter** (Add Lines 2 and 4) ..... **5.** \_\_\_\_\_

**PART III HEALTH CARE CONTRIBUTIONS**

- 6.**  Check here to certify that no Health Care Contribution is due based on the rules governing this reporting.
- 7.** Adjusted Uncovered FTE (from Form HC-1,  
 Health Care Contributions Worksheet, Line D)..... **7.** \_\_\_\_\_
- 8.** Total Health Care Contributions Due (from Form HC-1, Line E)..... **8.** \_\_\_\_\_

**PART IV BALANCE**

- 9.** Total due (Add Lines 5 and 8)..... **9.** \_\_\_\_\_
- 10.** Vermont withholding tax already paid this quarter ..... **10.** \_\_\_\_\_
- 11. Refund** (If Line 10 is greater than Line 9, subtract Line 9 from Line 10.)..... **11.** \_\_\_\_\_
- 12. TOTAL Withholding Tax and Health Care Contributions Due**  
 (If Line 9 is greater than Line 10, subtract Line 10 from Line 9.) ..... **12.** \_\_\_\_\_

**PART V SIGNATURE**

I hereby certify that I have examined this return and to the best of my knowledge and belief it is true, correct, and complete.			
Signature of Officer or Authorized Agent _____ Date _____	Preparer's Signature _____ Date _____		
Title _____	Telephone Number _____	Firm's name (or yours, if self-employed) and address _____	

<input type="checkbox"/> Check here if authorizing the Vermont Department of Taxes to discuss this return and attachments with your preparer.	Preparer's Telephone Number _____	Preparer's PTIN or EIN _____
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