

ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form



[Need Help?](#)

** Required Fields*

Current Date: _____

* Legal Business Name (LBN): _____

* Federal Tax ID Number: _____

Billing Contact

* First Name: _____ * Last Name: _____ * Job Title: _____

* Email Address: _____ * Telephone: _____ Ext: _____

Billing Address

* Line 1: _____ Line 2: _____

* City: _____ * State: _____ * Zip Code: _____

Contact for Submission

* First Name: _____ * Last Name: _____ * Job Title: _____

* Email Address: _____ * Telephone: _____ Ext: _____

* Are you reporting for three (3) or fewer Contributing Entities using this Form? ? Yes No

* If yes, are you both the Reporting Entity and Contributing Entity for this Form submission? ? Yes No

ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form



[Need Help?](#)

Contributing Entity 1:

* Legal Business Name (LBN): _____

* Federal Tax ID Number: _____ * Organization Type: _____

Billing Address

* Line 1: _____ Line 2: _____

* City: _____ * State: _____ * Zip Code: _____

* Domiciliary State: _____

* Benefit Year: 2016 * Annual Enrollment Count for the applicable benefit year: _____

* Indicate Type of Contributing Entity: _____ ?

* Other Type: _____

Contributing Entity 2 ?

* Legal Business Name (LBN): _____

* Federal Tax ID Number: _____ * Organization Type: _____

Billing Address

* Line 1: _____ Line 2: _____

* City: _____ * State: _____ * Zip Code: _____

* Domiciliary State: _____

* Benefit Year: 2016 * Annual Enrollment Count for the applicable benefit year: _____

* Indicate Type of Contributing Entity: _____ ?

* Other Type: _____

Contributing Entity 3 ?

* Legal Business Name (LBN): _____

* Federal Tax ID Number: _____ * Organization Type: _____

Billing Address

* Line 1: _____ Line 2: _____

* City: _____ * State: _____ * Zip Code: _____

* Domiciliary State: _____

* Benefit Year: 2016 * Annual Enrollment Count for the applicable benefit year: _____

* Indicate Type of Contributing Entity: _____ ?

* Other Type: _____

ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form



[Need Help?](#)

* Type of Filing ?

- New
 Re-Filing
 Resubmission
 Invoice

* Do you want to make the Full Contribution for 2016 in one payment? ?

- Yes
 No

* If No, select one of the two payments for which you are filing this Form. ?

- (1) First Collection - \$21.60 per covered life.
(Regulatory Payment Due Date - January 17, 2017)

 (2) Second Collection - \$5.40 per covered life.
(Regulatory Payment Due Date - November 15, 2017)

* Benefit Year for Reporting Annual Enrollment Count _____ 2016

Total Applicable Benefit Year Contribution Rate _____

* Annual Enrollment Count _____ ?

* Verify Annual Enrollment Count _____ ?

Contribution Rate for Program Payments and Program Administration Funds _____ ?

Contribution Amount Due for Program Payments and Program Administration Funds _____ ?

Contribution Rate for General Fund of the US Treasury _____ ?

Contribution Amount Due for General Fund of the US Treasury _____ ?

Total Contributions Due for the Applicable Benefit Year _____ ?

* Previous Pay.gov Tracking ID _____ ?

* Invoice Number _____ ?

* Verify Invoice Number _____ ?

* Invoice Payment Amount _____ ?

* Annual Enrollment Count _____ ?

* Verify Annual Enrollment Count _____ ?

The Annual enrollment count entered in this Form is accurate and matches the aggregate enrollment count by entity in the Supporting Documentation, if applicable. ?

Acknowledgment: My acknowledgment is on behalf of my organization and the contributing entity or entities for which the data and accompanying payment(s) are being submitted. My acknowledgment legally and financially binds my organization and each contributing entity to the applicable laws, regulations and program instructions of the Affordable Care Act (ACA). By my submission, I certify that the data are true, correct and complete. If my organization or any contributing entity becomes aware that data are untrue, incorrect or incomplete, CMS shall be promptly informed. If CMS identifies a discrepancy or has questions about the data being submitted, I agree to be the contact for responding to such questions. I acknowledge that the provisions of the Affordable Care Act specifically make payments made by or in connection with an Exchange subject to the False Claims Act if those payments include any Federal funds. This includes, but is not limited to, the transitional reinsurance program established under Section 1341 of the Affordable Care Act.

Authorizing Official for Reporting Entity's Acknowledgment

* First Name: _____ * Last Name: _____ * Job Title: _____

* Email Address: _____ * Telephone: _____ Ext: _____