ACA Transitional Reinsurance Program
Annual Enrollment and Contributions Submission Form

Current Date: 10/26/2014

Legal Business Name (LBN): _____

Federal Tax ID Number: _____

Billing Contact

First Name: _____ Last Name: _____ Title: _____

Email Address: _____ Telephone: _____ Ext: _____

Billing Address

Line 1: _____ Line 2: _____

City: _____ State: _____ Zip Code: _____

Contact 1 for Submission

First Name: _____ Last Name: _____ Title: _____

Email Address: _____ Telephone: () - _____ Ext: _____

Contact 2 for Submission

First Name: _____ Last Name: _____ Title: _____

Email Address: _____ Telephone: _____ Ext: _____

Contact 3 for Submission

First Name: _____ Last Name: _____ Title: _____

Email Address: _____ Telephone: _____ Ext: _____

Continue

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Type of Payment

- ☐ First Collection - Contribution for Program Payments and Program Administration Funds
- ☐ Second Collection - Contribution for General Fund of the US Treasury
- ☐ Combined Collection - First Collection + Second Collection (as described above)
- ☐ Invoice
- ☐ Resubmission - File Attachment

Benefit Year for Reporting Gross Annual Enrollment Count	
Total Applicable Benefit Year Contribution Rate	
Gross Annual Enrollment Count	
Verify Gross 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	
Pay.gov Tracking ID	
Invoice Number	
Verify Invoice Number	
Invoice Payment Amount	
Gross Annual Enrollment Count	
Verify Gross Annual Enrollment Count	

☐ The gross annual enrollment count entered in this form matches the aggregate enrollment count by entity in the supporting documentation.

☐ 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: _____ Title: _____

Email Address: _____ Telephone: _____ Ext: _____

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