TAX & BOOKKEEPING

1 (800) 879-6605 | **FAX:** (914) 696-7505 | **SUBMIT ONLINE:** dsatax.com

EMAIL: to your Tax Rep | **MAIL:** copy of your Questionnaire to

2900 Westchester Avenue, Suite 201, Purchase NY 10577

Business Name:	**DSA # / EIN:**
for the Tax Year: 20	**ACCT REP:**

Health Insurance Questionnaire

As an employee of your company, if you **pay quarterly payroll taxes** via Form 941 and pay health insurance premiums (**not through a spouse's plan**), these premiums are tax deductible for your business.

PART ONE

Is your Health Insurance covered under your Spouse's plan? ☐YES ☐NO

*If you answer "**YES**", you can **STOP** here and return this Questionnaire to DSA*

PART TWO **only** pertains to Health Insurance you pay for, **not paid for under a spouse's plan**.

PART TWO

Do you personally pay for Health Insurance (including Dental & Vision)? ☐YES ☐NO

Please mark one box to show who is covered under your plan:

☐SELF

☐SELF & SPOUSE

☐FAMILY

What is your Monthly Premium amount (for Health, Dental & Vision)? $

Are other expenses, *besides Health Insurance* , included on your Monthly Report? ☐YES ☐NO

If **yes**, please indicate below:

If your amount includes a portion for ***Dental Insurance*** , please list the amount:	$
If your amount includes a portion for ***Vision Insurance*** , please list the amount:	$
If your amount includes a portion for ***Life Insurance*** , please list the amount:	$
If your amount includes a portion for ***Disability Insurance*** , please list the amount:	$
If your amount includes a portion for ***Business Insurance*** , please list the amount:	$
If your amount includes a portion for **another type of *Insurance*** , please list the amount:	$
Please describe this other type of Insurance :	

Do you have a copy of your current policy or policy renewal? ☐YES ☐NO

If **yes**, please attach a copy of your policy

Please return this Questionnaire to DSA as soon as possible!