



HEALTH CARE SECURITY ORDINANCE (HCSO) - MANDATORY ANNUAL REPORTING FOR 2008

RETURN TO: SAN FRANCISCO OFFICE OF LABOR STANDARDS ENFORCEMENT

P.O. BOX 7378
San Francisco, CA 94120-7378

FOR ASSISTANCE: Refer to the enclosed instructions, visit
<http://www.sfgov.org/olse/hcso>, or call (415) 554-7892

Business Certificate Number

Business Name and Address

DELINQUENT AFTER April 30, 2009

Covered Employers must complete all of the questions below. Failure to do so shall constitute a violation of § 14.3(b) of Chapter 14 of the SF Admin. Code. Violators shall be subject to penalties and other corrective action.

FILL THIS CIRCLE IN COMPLETELY IF YOU ARE FILING THIS FORM ON BEHALF OF SEVERAL ENTITIES IN THE SAME "CONTROL GROUP."

For each quarter, enter the following information:		1st Quarter: January to March 2008	2nd Quarter: April to June 2008	3rd Quarter: July to September 2008	4th Quarter: October to December 2008
A	Number of Employees Employed per Week (anywhere): <i>NOTE: Employers with 19 or fewer employees are NOT covered by the HCSO and should NOT complete or file this form.</i>	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+	<input type="radio"/> 20-49 <input type="radio"/> 100-499 <input type="radio"/> 50-99 <input type="radio"/> 500+
IMPORTANT: The remaining questions refer only to those employees covered by the HCSO.					
B1	Total Number of "Covered Employees": <i>Do not count employees exempt from coverage under this law; see instructions for more details.</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
B2	Total Number of Employees Exempt From Coverage Under the HCSO, <i>including those who have signed Voluntary Waivers</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C	Total Number of Hours Paid to All Covered Employees: <i>Hours paid includes both hours worked and hours for which covered employees were entitled to be paid wages, such as paid vacation hours, paid time off, and paid sick leave hours, but not exceeding 172 hours/month or 516 hours/quarter.</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	Total Amount of Health Care Expenditures Made for All Covered Employees (in whole dollars; do not include commas or cents)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E	Breakdown of Health Care Expenditures Made by the Employer: <i>Count each covered employee only once per quarter; if your business made more than one type of health care expenditure for an employee, count that employee in the category in which the largest health care expenditure was made.</i>				
E1	Number of Covered Employees enrolled in group health insurance coverage	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E2	Number of Covered Employees enrolled in self-insured group health plan. <i>Please review the instructions to determine if your plan meets the definition of a self-insured plan.</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E3	Number of Covered Employees enrolled in health/medical reimbursement, spending, or savings account administered by a third party vendor	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E3(a)	Total <u>annual</u> dollar amount of funds made available to Covered Employees for 2008 -- how much the employer made available via third-party health/medical reimbursement, spending, or savings accounts (in whole dollars; do not include commas or cents)			\$ <input type="text"/>	
E3(b)	Total <u>annual</u> dollar amount of reimbursements made to Covered Employees for 2008 -- how much employees were reimbursed via third-party health/medical reimbursement, spending, or savings accounts (in whole dollars; do not include commas or cents)			\$ <input type="text"/>	
E4	Number of Covered Employees for whom the employer provided direct reimbursement or made direct payments for health care expenses	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E4(a)	Total <u>annual</u> dollar amount of funds made available to Covered Employees for 2008 -- how much the employer made available for direct reimbursements or payments			\$ <input type="text"/>	
E4(b)	Total <u>annual</u> dollar amount of funds spent for Covered Employees for 2008 -- how much Covered Employees were reimbursed and/or how much was paid directly by the employer for Covered Employees' health care expenses (in whole dollars; do not include commas or cents)			\$ <input type="text"/>	
E5	Number of Covered Employees for whom payment was made for the City Option <i>(includes both Healthy San Francisco and the City's Medical Reimbursement Account)</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
E6	Other: <i>(describe):</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

By submitting this report the above-named employer certifies the following: (1) that the information on this reporting form is correct; (2) that all compensable hours paid to the employees who performed work in the geographic boundaries of the City and County of San Francisco during the period covered by this report are reported herein; (3) that this report, whether or not signed in the space provided below, is being submitted by the employer or duly authorized representative of the employer. Under the laws of the State of California, I declare under penalty of perjury that I have read the foregoing and that it is true, correct, and complete to the best of my knowledge and belief.

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SIGN HERE _____

DATE _____, 2009



REMEMBER:

- Incomplete forms cannot be processed. Be sure to include your business name and address in the top left-hand corner of the form, as well as your Business Account or Certificate Number in the box provided.
- Only one Annual Reporting Form (ARF) is required. If you have already downloaded, completed, and returned the ARF available from our website, do not return the ARF in this mailing.
- Mail your completed ARF to:
P.O. Box 7378
San Francisco, CA 94120-7378
Do not return the ARF to the OLSE's City Hall address.