ACA Transitional Reinsurance Program
Annual Enrollment and Contributions Submission Form

Need Help?

** Required Fields*

Current Date: 11/19/2016

* Legal Business Name (LBN): Madison County

* Federal Tax ID Number: 64-6000658

Billing Contact

* First Name: Shelton * Last Name: Vance * Job Title: Comptroller

* Email Address: comptroller@madison-co.com * Telephone: (601) 855-5502 Ext:

Billing Address

* Line 1: PO Box 608 Line 2:

* City: Canton * State: Mississippi * Zip Code: 39046

Contact for Submission

* First Name: Shelton * Last Name: Vance * Job Title: Comptroller

* Email Address: shelton.vance@madison-co.com * Telephone: (601) 855-5502 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

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Contributing Entity 1:

* Legal Business Name (LBN): Madison County
* Federal Tax ID Number: 64-6000658
* Organization Type: Nonprofit

Billing Address

* Line 1: PO Box 608
Line 2:
* City: Canton
* State: Mississippi
* Zip Code: 39046
* Domiciliary State: Mississippi
* Benefit Year: 2016
* Annual Enrollment Count for the applicable benefit year: 659.00
* Indicate Type of Contributing Entity: (2) Self Insured Group Health Plan ?
* 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:

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* 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)

Field	Value
* Benefit Year for Reporting Annual Enrollment Count	2016
Total Applicable Benefit Year Contribution Rate	27.00
* Annual Enrollment Count ?	659.00
* Verify Annual Enrollment Count ?	659.00
Contribution Rate for Program Payments and Program Administration Funds ?	21.60
Contribution Amount Due for Program Payments and Program Administration Funds ?	14,234.40
Contribution Rate for General Fund of the US Treasury ?	5.40
Contribution Amount Due for General Fund of the US Treasury ?	3,558.60
Total Contributions Due for the Applicable Benefit Year ?	17,793.00
* Previous Pay.gov Tracking ID ?	
* Invoice Number ?	
* Verify Invoice Number ?	
* Invoice Payment Amount	
* Annual Enrollment Count ?	
* Verify Annual Enrollment Count ?	

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

[X] 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: Shelton * Last Name: Vance * Job Title: Comptroller

* Email Address: shelton.vance@madison-co.com * Telephone: (601) 855-5502 Ext: