A.R.S. § 43-210
Application for Certificate of Eligibility for the Health Insurance Premium Tax Credit – Small Business Only

Please Print

Small Business Applicant Name:		
Small Business Applicant Address Number and Street or PO Box:		
City:	State	ZIP Code
Small Business Owner or Contact Person Name(s)		
Small Business Owner or Contact Person Day-Time Phone Number		
Length of time Small Business has been in existence in Arizona		
Maximum number of employees at any time during the most recent calendar year		
Number of employees seeking Single Coverage		
Number of employees seeking Family Coverage		

Print

I declare that the above-named small business has not provided health insurance to its employees for at least six consecutive months prior to this application.

Under penalties of perjury, I declare that I have examined this application and to the best of my knowledge and belief, this information is true, correct and complete.

Signature _____ Date _____

This application should be mailed to the following address:

Arizona Department of Revenue
Office of Economic Research and Analysis
Darlene Teller, Senior Economist
PO Box 29099
Phoenix, AZ 85038

If you have questions regarding completion of this form, contact Darlene Teller at (602) 716-6436.