

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

Please Print

Small Business Name:		
Small Business Address Number and Street or PO Box:		
City:	State	ZIP Code
Name of Small Business Contact Person		
Small Business Contact Person's Phone Number and E-mail Address		
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		

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

E-mail application to healthinsurancepremiumtc@azdor.gov or fax to (602) 716-7991.

If E-mail or fax is not an option, applications can be mailed to:

Arizona Department of Revenue
Office of Economic Research and Analysis
Health Insurance Premium Tax Credit
PO Box 29099
Phoenix, AZ 85007

If you have questions regarding this form, contact healthinsurancepremiumtc@azdor.gov or (602) 716-6924.