EMPLOYER ANNUAL REPORTING FORM 2018 – HCSO AND FCO

Introduction

Answer these questions to find out if you need to complete a 2018 Employer Annual Reporting Form. More information

1) Did any employees work in San Francisco for an average of 8 hours per week or more (104 hours per quarter) during any quarter of 2018? Include employees who worked from home in San Francisco.

○ **Yes** ○ **No**

2) Is the employer a for-profit or a non-profit entity?

○ **For-profit** ○ **Non-profit**

3) How many people performed work for the employer each week? Include all workers worldwide. If the number fluctuated, see the instructions.

○ **0-19** ○ **20-49** ○ **50-99** ○ **100+**

4) Did the employer have a contract to perform work for the City and County of San Francisco during 2018?

○ **Yes** ○ **No**

Next **Reset**

Getting Started

Based on your answers to the introductory questions, you must complete the 2018 Employer Annual Reporting Form.

The form is due by Tuesday, April 30, 2019. Employers who do not submit a form may receive a penalty of $500 per quarter.

Read the Instructions before you begin. If you need help completing the form, sign up for a 2018 Employer Reporting Form Webinar.

You will need a San Francisco Business Account Number to complete the form. You can find this number:

- On your Business Registration Certificate issued by the San Francisco Treasurer & Tax Collector.
- On the San Francisco Data website.

If you have not registered with the S.F. Treasurer and Tax Collector's Office, you will need to register before completing this form. **Register here.**

Enter your 7-digit S.F. Business Account Number and click "Validate". If it has only 6 digits, enter a zero first.

Business Account Number

Validate

Business Name:

Is this your Business? **Continue** **Cancel**

Business Size

How many people worked for your business in each quarter of 2018? More information

	1st Quarter January to March 2018	2nd Quarter April to June 2018	3rd Quarter July to September 2018	4th Quarter October to December 2018
• Count ALL individuals including those outside SF	◉ 0-19	◉ 0-19	◉ 0-19	◉ 0-19
	○ 20-49	○ 20-49	○ 20-49	○ 20-49
	○ 50-99	○ 50-99	○ 50-99	○ 50-99
	○ 100-499	○ 100-499	○ 100-499	○ 100-499
	○ 500-1999	○ 500-1999	○ 500-1999	○ 500-1999
	○ 2000+	○ 2000+	○ 2000+	○ 2000+

Employees Covered by the HCSO

How many employees were entitled to health care spending from your business under the San Francisco Health Care Security Ordinance in each quarter of 2018?
More information

	1st Quarter January to March 2018	2nd Quarter April to June 2018	3rd Quarter July to September 2018	4th Quarter October to December 2018
Covered Employees	0	0	0	0

Health Insurance

Did the employer spend money on health insurance premiums for employees covered by the HCSO? (Includes medical, dental, and vision premiums. Also includes payments for health benefits to a labor management trust fund.)

◉ **Yes** - Please complete the sections below.

○ **No**

For employees covered by the HCSO, list:
1) the total number of employees for whom you made health insurance premium payments
2) the total dollar amount of your quarterly health insurance premiums. Note: if you provided self-funded insurance plans and calculated the expenditures on an annual basis under HCSO Rule 5.10, please do not include expenditures for those plans in the "amount employer spent" here. See the instructions for more information.

	1st Quarter January to March 2018	2nd Quarter April to June 2018	3rd Quarter July to September 2018	4th Quarter October to December 2018
Covered Employees	0	0	0	0
Amount employer spent ($)	0	0	0	0

Please check all of the types of expenditures you made (including self-funded plans):

- ☐ Medical insurance premiums
- ☐ Dental insurance premiums
- ☐ Vision insurance premiums
- ☐ Contributions for health benefits to a labor management trust fund

Were any of your health insurance payments for a self-insured or self-funded health plan?

◉ **Yes**

○ **No**

If yes, did you use an annual average hourly expenditure calculation to determine whether one or more of your plans met the spending requirement under HCSO Rule 5.9(b)?

◉ **Yes**

○ **No**

If yes, please download and complete this Self-Funded Plan Addendum to the Employer Annual Reporting Form. This addendum must be emailed to hcso@sfgov.org with the subje line "Self-Funded Form".

See the end of this document for the Self-Funded Plan Addendum screenshots

City Option

Did the employer make contributions to the SF City Options for covered employees? These contributions provide employees with access to 3 possible SF City Option programs including SF MRA, and SF CoveredMRA, or Healthy San Francisco.

More information

(•) **Yes** - Please complete the sections below.

( ) **No**

For the employees covered by the HCSO, indicate:
1) the total number for whom you made contributions to the SF City Option; and
2) the total dollar amount contributed to the SF City Option, per quarter.

If your company made contributions to SF City for Covered Employees in 2018, you can obtain the total number of employees and total dollar amount by logging into your company's Employer Portal Account at https://employerportal.healthysanfrancisco.org/ and reviewing your paid rosters for each quarter. If you have additional questions about SF City Option, email employerservices@sfcityoption.org.

	1st Quarter January to March 2018	2nd Quarter April to June 2018	3rd Quarter July to September 2018	4th Quarter October to December 2018
Covered Employees	0	0	0	0
Amount employer contributed ($)	0	0	0	0

Use buttons at the bottom of this form to navigate forward and backwards. Do not use the back button in your internet browser or you may lose your answers.

Other Health Care Expenditures

Did you make other Health Care Expenditures for your employees covered by the HCSO, such as contributions to Health Savings Accounts?

More information

(•) **Yes** - Please complete the sections below.

( ) **No**

What type of health care expenditure did you make for 2018?

Note: Revocable expenditures were not valid in 2018. Do not include amounts contributed to Flexible Spending Accounts, Revocable HRAs, and other revocable benefits or accounts.

- [ ] Health Savings Account
- [ ] Medical Savings Account
- [ ] Irrevocable Health Reimbursement Account
- [ ] OLSE-directed self-audit
- [ ] Other type of Health Care Expenditure Description:

For the employees covered by the HCSO, indicate:
1) the total number for whom you spent money on this benefit; and
2) the total dollar amount of the employer payments, per quarter (do not include amounts contributed by the employee).

	1st Quarter January to March 2018	2nd Quarter April to June 2018	3rd Quarter July to September 2018	4th Quarter October to December 2018
Number of Covered Employees	0	0	0	0
Amount Employer Spent ($)	0	0	0	0

Surcharge

Did you impose a surcharge on your customers at any time in 2018 to cover, in whole or in part, the costs of providing health care and/or complying with the HCSO?

More information

- (•) **Yes** - Please complete the sections below.
- ( ) **No**

If yes, how much did you collect (in dollars) from your customers in 2018 through this surcharge for employee health care?

If yes, please enter the language on your menu and receipts to identify the surcharge:

Fair Chance Ordinance Reporting

The San Francisco Fair Chance Ordinance requires employers **to follow strict rules regarding the use of arrest and conviction records in hiring and employment decisions.** The law was amended effective October 1, 2018.

Employers covered by the law are required to report to the OLSE. More information

1) How many employees did your company hire to work in San Francisco during 2018 (including telecommuters working in San Francisco)?

0

2) During 2018, did your company's employment application for jobs in San Francisco, including online applications, ask about arrest or conviction records?

Yes **No**

3a) Between January 1, 2018 and September 30, 2018, did your business conduct criminal background checks for any applicants before you conducted a live interview with them?

Yes **No**

3b) Between October 1, 2018 and December 31st, 2018, did your business conduct criminal background checks for any applicants before making a conditional offer of employment?

Yes **No**

4) The FCO prohibits employers from inquiring about the following at any time:

- An arrest not leading to a conviction, except for unresolved arrests;
- A conviction that is more than 7 years old;
- Participation in a diversion or deferral of judgment program;
- A conviction that has been dismissed, expunged, or otherwise invalidated;
- A conviction in the juvenile justice system;
- An offense other than a felony or misdemeanor, such as an infraction
- A conviction for decriminalized conduct, including the non-commercial use and cultivation of cannabis (as of October 1, 2018)

Did your company inquire about any the above in 2018?

Yes **No**

6) Did you hire anyone with a conviction history during 2018?

?

Yes **No** **Do not know**

If Yes, how many? 0

7) Is your business exempt from any of the FCO's provisions (either because you are required to conduct background checks under state or federal law, or because your employees are drivers or work with children, seniors, or disabled individuals)? More Information

Yes **No**

Certification

By submitting this form, I certify that the information on this form is being submitted by the registered owner of the business or a duly authorized representative of the entity. Under the laws of the State of California, I declare under penalty of perjury that I have read the foregoing and that the information being submitted is true, correct, and complete to the best of my knowledge and belief.

Name*

Email* Confirm Email*

Title Telephone *

* Required fields.

This form is public and subject to public disclosure.

Please review all of your answers in all the pages carefully by clicking on the top navigation buttons or the bottom Previous and Next buttons before submitting your Annual Reporting Form. Once you submit the form, a copy will be sent to the email address provided above. Please retain that copy in your records.

Use buttons at the bottom of this form to navigate forward and backwards. Do not use the back button in your internet browser or you may lose your answers.

Self-Funded Insurance Plan Addendum
to the 2018 San Francisco Employer Annual Reporting Form

Email your completed Self-Funded Insurance Addendum to hcso@sfgov.org with the subject "Self-Funded Plan Form"

Business Account Number	
Business Name	

Self-Funded Insurance Plans

Complete one row for each self-funded plan for which the employer completed an annual average hourly expenditure calculation. Indicate the type of plan - medical, dental, or vision.

	Type of Plan (medical, dental, vision, or other)	Annual Average Hourly Expenditures for 2018
Self-Funded Plan 1		
Self-Funded Plan 2		
Self-Funded Plan 3		
Self-Funded Plan 4		
Self-Funded Plan 5		
Self-Funded Plan 6		
Self-Funded Plan 7		

Top-off Payments for Self-Insured Plans

After calculating the employer's annual expenditures for self-funded plans, did the employer make top-off payments for any of the self-insured plans to satisfy the Health Care Expenditure requirements for 2018?

Types of Top-off Payments

If the employer made top-off payments to satisfy the HCSO spending requirement, list the type of the payments (for all self-funded plans), the total amount of the payments, and the number of employees covered by the HCSO who received each type of top-off payment.

Type of Payment	Total Amount of Top-Off	Number of Covered Employees