



YEAR END FRINGE FORM
(PLEASE COMPLETE ONE PER EMPLOYEE)

S-CORP INSURANCE PREMIUM

COMPANY: _____ COMPANY ID _____
EMPLOYEE: _____ EMPLOYEE # _____
CHECK DATE: _____

GROSS AMOUNT \$ _____

FICA 6.2% _____ **N/A**

MEDICARE 1.45% _____ **N/A**

FEDERAL TAX \$ _____

STATE TAX \$ _____

CITY TAX _____ **N/A**

(Work City)

DEDUCTION \$ _____

(Back out value of S-Corp)

NET \$ _____ -0-

REQUESTED BY _____

(person completing the form)

DATE _____

IMPORTANT NOTICE The S-Corp Insurance premium must be added to the employee's payroll check. **THIS FRINGE MAY NOT BE GROSSED UP.**