**Massachusetts Paid Family & Medical Leave Tax Authorization**

**Employer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer Payroll Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This form is designed to assist us identify the different employer types for this tax and to ensure that your payroll account is setup properly for the MA PFML tax.

This tax becomes effective October 1st, 2019 and will be calculated at a rate of 0.75% of the employee’s eligible wages to a limit of $132,900. The employee contribution for this tax is a maximum of 0.378%. Employers can elect to pay any amount of this portion at will for their employees.

The employer portion of this tax is only required if you have 25 or more eligible employees. The minimum taxable rate for a required employer is 0.372%. Employers who are not required to pay the tax can elect to pay any amount of the employees portion up to the maximum .75%.

Employees eligibility is determined using the same rules for the MA State Unemployment Insurance rules. These can be found [here](https://www.mass.gov/files/documents/2018/04/05/Employer%20Handbook_4-2-18_2.pdf) on pages 7 and 8 under section C.

1. Are you a SUI eligible employer or do you pay SUI taxes? [ ]  Yes | [ ]  No
2. Do you have a state approved voluntary plan exempting you from this tax? [ ]  Yes | [ ]  No
3. If you answered yes to question 1, how many SUI eligible employees did you have in fiscal year 2018? \_\_\_\_\_\_\_\_
	1. If this number is 24 or below, you are **not** required to contribute for your employees, but may still continue to step three if you would like to contribute anyway.
4. If you would like to cover any of the tax for your employees, please specify what percentage of the employee tax you would like to be responsible for: \_\_\_\_\_\_\_\_%

Please fill out this form and return to your payroll representative or team.

Authorized Employer Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Print Name)

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_