BENEFIT/EMPLOYMENT VERIFICATION FORM

Employee Information

Employee Name (Last Name, First Name, MI)	**Employee Date of Birth**
Presently Employed ☐Yes If Yes, Date First Employed _____/_____/_____	☐No If No, Last date of Employment _____/_____/_____
Job Title	
Employment Status (Check ALL that apply) ☐ Full-Time ☐ Part-Time ☐ *Seasonal ☐*Temporary	***Describe Temporary/Seasonal Circumstance**

Current Wages/Salary:

$_____ **(Check one)** **Hourly** ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Semi-Monthly** ☐ **Monthly** ☐ **Annual** ☐

Insurance Eligibility

Is employee eligible for company offered healthcare benefits? ☐Yes ☐No

Employee currently enrolled? ☐Yes ☐No If No, Benefit Termination Date: _____/_____/_____

If able, when can employee add a qualifying member? Date: _____/_____/_____

Future Eligibility? ☐Yes ☐No

If Yes, Earliest date employee can enroll? _____

If client were to enroll during that time, when would coverage take effect? _____

Insurance Information

Employee's portion of EMPLOYEE ONLY premiums for MEDICAL ONLY

$_____ **(Check one)** **Hourly** ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Semi-Monthly** ☐ **Monthly** ☐ **Annual** ☐

Insurance Carrier Name & Phone Number	**Are pharmacy benefits available?** ☐Yes ☐No

Additional Remarks

_____

Employer/HR Print (First and Last Name)	**Date Form Completed**

Employer/HR Signature

Company Name

Company Address

Contact Phone Number

Applicant is responsible to return document for processing.

REF URN: _____