

BENEFIT/EMPLOYMENT VERIFICATION FORM**Employee Information**

Employee Name (Last Name, First Name, MI)	Employee Date of Birth
Presently Employed <input type="checkbox"/> Yes If Yes, Date First Employed ____/____/____	<input type="checkbox"/> No If No, Last date of Employment ____/____/____
Job Title	

Employment Status (Check ALL that apply) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> *Seasonal <input type="checkbox"/> *Temporary	*Describe Temporary/Seasonal Circumstance
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Additional Remarks

Employer/HR Print (First and Last Name)	Date Form Completed
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Employer/HR Signature	<p>Applicant is responsible to return document for processing.</p> <p>REF URN: _____</p>
Company Name	
Company Address	
Contact Phone Number	

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