Employer Insurance Verification

Name: _____ Social Security Number: _____

Please have your <u>employer</u> provide the following information.

Do you, as an employer, offer coverage under any insurance plan for medical, vision and dental coverage that equals or exceeds the minimum standards for Accident & Sickness policies? Yes No N/A

If yes, is the individual listed above eligible for:

- **Medical** (_____) Yes No N/A
  Insurance company
- **Vision** (_____) Yes No N/A
  Insurance company
- **Dental** (_____) Yes No N/A
  Insurance company

If yes, is the employee named above currently enrolled in:

- **Medical** Yes No N/A
  - Is there a spending cap? Yes No N/A

If Yes, what is the spending cap? $_____ Frequency: Monthly Annually N/A

- **Vision** Yes No N/A
  - Is there a spending cap? Yes No N/A

If Yes, what is the spending cap? $_____ Frequency: Monthly Annually N/A

- **Dental** Yes No N/A
  - Is there a spending cap? Yes No N/A

If Yes, what is the spending cap? $_____ Frequency: Monthly Annually N/A

If employee is eligible for coverage what was the first date of coverage?

<u>Eligible for Coverage</u>	**<u>Date Coverage Began</u>**	**<u>Date Coverage Ends</u>**
Medical ____/____/_____	Medical ____/____/_____	Medical ___/___/____
Vision ____/____/_____	Vision ____/____/_____	Vision ___/___/____
Dental ____/____/_____	Dental ____/____/_____	Dental ___/___/____

If the individual is not eligible, please explain why and attach any relevant information or documentation.

_____

_____

_____

Please provide dates of open enrollment _____/____/_____

I sign this affidavit testifying that the above information is correct.

_____

Signature Printed Name Date

_____

Title Company Name Phone Number