

EMPLOYER VERIFICATION OF INSURANCE COVERAGE

Directions: The employee must sign and date this form and then give it to the employer to complete. The employer completes and returns this form **ONLY** if the employee/dependents are **CURRENTLY** enrolled or have been accepted for coverage in the employer's group health insurance plan. Thank you.

Permission to Release Information

My employer has my permission to give information about my health insurance benefits to staff of the Iowa Department of Human Services. This information may be discussed either verbally or in writing. This permission will end thirteen months from the date of my signature. I understand that I have the right to notify my employer if I want the permission to end at an earlier date.

Name of Employee (Please print)	SSN
Signature of Employee X	Date

To Be Completed by Employer

1. List ALL persons covered under the plan and enter the effective date of their coverage:

Covered person's name	Date of Birth	Eff. Date of Medical	Eff. Date of Dental	Eff. Date of Vision

Please list the name and address of the insurance companies on the back of this page. Over →

2. Circle the day of the week the employee gets paid: M T W Th F Sa Su

3. Frequency of payroll deduction for insurance: **Biweekly 24** **Weekly 48** **Semi Monthly**
Biweekly 26 **Weekly 52** on (dates): _____ & _____
Monthly indicate date each month: _____

4. If the employee is newly enrolled, what is the first pay date of the insurance deduction? If this employee is already enrolled, what is the next pay date? (pay date): ____/____/____

The premium deducted on this pay date is for insurance coverage for the time period of

____/____/____ to ____/____/____

5. What is the **employee's** cost of insurance **per pay check** for:

Medical \$ _____ Dental \$ _____ Rx \$ _____ Vision \$ _____

**If cafeteria or flex dollars are used to reduce the premiums, please attach proof as to how they are applied.

CHOOSE ONE PAYMENT OPTION

6. Who do you want DHS to reimburse? The employee or The employer

If the employer in lieu of a payroll deduction, list the address where to send payments below:

If paying the employer directly, what is the date the first insurance premium is due? _____

Health Insurance Carrier Name and Address

Name: _____
 Address: _____
 City/State/Zip: _____

Dental Insurance Carrier Name and Address

Name: _____
 Address: _____
 City/State/Zip: _____

Rx Insurance Carrier Name and Address

Name: _____
 Address: _____
 City/State/Zip: _____

Vision Insurance Carrier Name and Address

Name: _____
 Address: _____
 City/State/Zip: _____

Employer Representative Name (print)		Signature of Employer Representative	
Date	Phone number	E-mail address	Employer Fed Tax ID No.

Employer Name: _____

Employer Address: _____

Employer City/State/Zip: _____

Employer's Website: _____

On what date are group policy premiums renewed each year? _____