

Standard Response to Verification of Employment

Employers will provide requested information normally maintained on employees. If additional information not listed on this form is needed, please contact the employer.

PAYROLL SECTION - Employee Personal Information

Full Name:

Last

First

M.I.

Residential
Address, if known:

Street Address

Apartment/Unit #

Mailing Address, if
known:

City

State

ZIP Code

Street Address

Apartment/Unit #

City

State

ZIP Code

Home
Phone:

Alternate Phone:

Email Address, if known:

Social
Security
Number:

Date of Birth:

Employer and Job Information

Employment Status: Currently Employed Terminated Never Employed

Title:

Dates of
Employ-
ment:

Employer Name:

Employer
Address:

Employer
Phone
Number:

Employer
Fax
Number:

Federal EIN:

Full/Part Time or Full Time Part Time

Begin Date:

End Date:

Seasonal: Seasonal

Return to Work Date:

Employee Work Site or
Location:

Termination Reason:

Voluntary

Involuntary

Wage Information

Pay Cycle/
Frequency:

Rate
of Pay: \$

Gross Pay Per
Period: \$

Net Disposable
Pay Per Period: \$

Current Year-to-Date Earnings: \$

Previous Calendar Year Earnings: \$ _____

Union Name: _____ Local Number: _____

Mandatory Union Dues: \$ _____ Mandatory Retirement: \$ _____

Tax Filing Status: Single Married Head of Household

Number of Dependents: _____

Workers' Compensation: Yes No

Name of Workers' Compensation
Company and Contact Information: _____

Certification Information

Completed by:

Employer Name (Employee's Employer) _____

Name: _____

Title: _____

Signature: _____

Date: _____

Phone number: _____

If additional information is needed, please contact the person listed above.

HEALTH INSURANCE SECTION - Employee Personal Information

Full Name: _____
Last First M.I.

Last 4 digits of Social Security Number: _____

Health Insurance Availability

Does the employer offer health insurance? Yes No

If not available currently to the employee, when will it be available? _____

Is health insurance available for dependents or spouse? Yes No

Is this paid by: Payroll Deduction Payment

Has the employee enrolled self and/or dependents? Self Dependents

Medical Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: \$ _____

Policy Group Name/Number: _____ Cost for Listed Children: \$ _____

Cost for Employee/Family: \$ _____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Dental Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: \$ _____

Policy Group Name/Number: _____ Cost for Listed Children: \$ _____

Cost for Employee/Family: \$ _____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Vision Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: \$ _____

Policy Group Name/Number: _____ Cost for Listed Children: \$ _____

Cost for Employee/Family: \$ _____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Prescription Drug Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: \$ _____

Policy Group Name/Number: _____ Cost for Listed Children: \$ _____

Cost for Employee/Family: \$ _____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Mental Health Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: \$ _____

Policy Group Name/Number: _____ Cost for Listed Children: \$ _____

Cost for Employee/Family: \$ _____

Complete the following information for each dependent: Cost Frequency: _____

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Other Health Insurance (specify type here):

Insurance Provider's Name: _____

Insurance Provider's Address: _____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: \$ _____

Policy Group Name/Number: _____ Cost for Listed Children: \$ _____

Cost for Employee/Family: \$ _____

Complete the following information for each dependent: Cost Frequency: _____

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Certification Information

Completed by:

Name and Title: _____

Company Name: _____

Signature: _____

Date: _____ Phone Number: _____