Standard Response to Verification of Employment/Income

Employers/Payors will provide requested information normally maintained on current and former Employees/Workers/Independent Contractors. Information listed below is provided if available. If additional information not listed on this form is needed, please contact the Employer/Payor.

Employee/Worker Information

Name: Other Name(s) Used:

SSN/TIN: Date of Birth:

Employment Status: Employed Never Worked Here No Longer Works Here Unpaid Leave of Absence

Employment Start Date: Employment End Date:

Part Time Full Time Seasonal (Usual Season Start Date: End Date:

Termination Reason: New Employer/Payor:

Independent Contractor: Yes No

Mailing Address:

Residential Address:

Home Phone Number: Cell Phone Number:

Email: Job Title/Occupation:

Work Site Address:

NOTE: Do not use worksite address for child support correspondence unless it is the Employer/Payor address.

Employer/Payor Information

Legal Name: DBA Name:

FEIN (Used to pay unemployment taxes):

Income Withholding for Support Orders (IWOs) Address:

Correspondence Address:

IWO Contact: Phone Number:

Fax Number: Email:

Employee/Worker Earnings

Pay Cycle: Monthly Semi-Monthly Bi-Weekly Weekly

Please provide the average over the past twelve months for:

Hours Worked per Pay Cycle: Rate of Pay/Cycle: ________________ Other:

Wages per Pay Cycle: Gross: Disposable:

Commissions per Pay Cycle: Gross: Disposable:

Other Types of Pay: Gross: Disposable:

NOTE: Other types of pay in addition to the regular rate of pay/period above.

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Employee/Worker Name: ________________________ SSN/TIN: ____________________________________

Employee/Worker Earnings

Amount of Other Mandatory Withholdings Deducted from the Disposable Earnings Reported Above:

Union Dues: Other (Please Specify):

Bonus/Lump Sum Payments: Yes No Frequency:

Employee/Worker Avg Overtime Disposable Earnings per Past Pay Cycle(s) Over Last Three Months:

Total Gross for Last Twelve Months: Number of Tax Exemptions:

Name of Tax Exemption Dependents:

Any withholdings or IWOs against earnings? Yes No

If Yes: Order Number: State: County: Amount Deducted:

Employee/Worker Health and Medical Insurance Benefits

Is Health or Medical Insurance Offered? Yes No If not available now, when will it be?

Note: If answer is yes, please complete Employee/Worker Benefits Addendum beginning on page 3.

Certification

- The records are maintained by the employer/benefit administrator.
- The information in the report was taken from records of the employment, compensation, and benefits of the identified employee/beneficiary.
- The information is maintained in the regular course of business.
- It is the regular course of such business to maintain such information; and
- That a memorandum or record of the information was made at the time of the act, transaction, occurrence, or event, or within a reasonable time thereafter.
- Information on tax withholdings including state and local taxes as well as Federal Insurance Contributions Act (FICA) payroll taxes.

Name: Title:

Date: Phone Number: Email Address:

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Employee/Worker Name: ________________________ SSN/TIN: ____________________________________

Employee/Worker Benefits Addendum

Has the employee/worker waived coverage? Yes No

Is health insurance available for: Dependents Spouse Ex-spouse

What is the month of open enrollment?

National Medical Support Notice Address:

Medical Insurance

Insurance Provider's Name:

Insurance Provider's Address:

Insurance Provider's Phone Number: Fax Number:

Email:

Policy Group Name/Number: Policy/Contract Number:

Is health insurance handled by a union or third party? Yes No If yes, provide information below.

Name: Phone:

Has Employee/Worker enrolled self? Yes No Employee/Worker enrolled dependents? Yes No

Individuals covered and start/effective dates [list below]:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Cost for Employee/Worker coverage only:

Monthly Semi- Monthly Bi-Weekly Weekly

Cost to Employee/Worker to extend coverage for dependents/child:

Monthly Semi- Monthly Bi-Weekly Weekly

Cost to Employee/Worker for family coverage:

Monthly Semi- Monthly Bi-Weekly Weekly

Plan Administrator's Name:

Plan Administrator's Address:

Plan Administrator's Phone Number: Email:

Available Insurance Coverage also includes: (Check all that apply)

Dental Vision Prescription Mental Health Other (Specify)

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Employee/Worker Name: ________________________ SSN/TIN: ____________________________________

Dental Insurance

Dental Insurance Provider's Name:

Dental Insurance Provider's Address:

Dental Insurance Provider's Phone Number: Fax Number:

Email:

Dental Policy Group Name/Number: Dental Policy/Contract Number:

Has Employee/Worker enrolled self? Yes No

Employee/Worker enrolled dependents? Yes No

Individuals covered and start/effective dates [list below]:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Cost for Employee/Worker coverage only:

Monthly Semi- Monthly Bi-Weekly Weekly

Cost to Employee/Worker to extend coverage for dependents/child:

Monthly Semi- Monthly Bi-Weekly Weekly

Cost to Employee/Worker for family coverage:

Monthly Semi- Monthly Bi-Weekly Weekly

Plan Administrator's Name:

Plan Administrator's Address:

Plan Administrator's Phone Number: Email:

Standard Response to Verification of Employment/Income

Employee/Worker Name: ________________________ SSN/TIN: ____________________________________

Prescription Insurance

Prescription Insurance Provider's Name:

Prescription Insurance Provider's Address:

Prescription Insurance Provider's Phone Number: Fax Number:

Email:

Prescription Policy Group Name/Number: Prescription Policy/Contract Number:

Has Employee/Worker enrolled self? Yes No

Employee/Worker enrolled dependents? Yes No

Individuals covered and start/effective dates [list below]:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Cost for Employee/Worker coverage only:

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Cost to Employee/Worker to extend coverage for dependents/child:

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Cost to Employee/Worker for family coverage:

Monthly Semi- Monthly Bi-Weekly Weekly

Plan Administrator's Name:

Plan Administrator's Address:

Plan Administrator's Phone Number: Email:

Standard Response to Verification of Employment/Income

Employee/Worker Name: ________________________ SSN/TIN: ____________________________________

Mental Health Insurance

Mental Health Insurance Provider's Name:

Mental Health Insurance Provider's Address:

Mental Health Insurance Provider's Phone Number: Fax Number:

Email:

Mental Health Policy Group Name/Number: Mental Health Policy/Contract Number:

Has Employee/Worker enrolled self? Yes No

Employee/Worker enrolled dependents? Yes No

Individuals covered and start/effective dates [list below]:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Cost for Employee/Worker coverage only:

Monthly Semi- Monthly Bi-Weekly Weekly

Cost to Employee/Worker to extend coverage for dependents/child:

Monthly Semi- Monthly Bi-Weekly Weekly

Cost to Employee/Worker for family coverage:

Monthly Semi- Monthly Bi-Weekly Weekly

Plan Administrator's Name:

Plan Administrator's Address:

Plan Administrator's Phone Number: Email:

Employee/Worker Name: ________________________ SSN/TIN: ____________________________________

Other Insurance

Type of Insurance:

Insurance Provider's Name:

Insurance Provider's Address:

Insurance Provider's Phone Number: Fax Number:

Email:

Policy Group Name/Number: Policy/Contract Number:

Has Employee/Worker enrolled self? Yes No

Employee/Worker enrolled dependents? Yes No

Individuals covered and start/effective dates [list below]:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Name: DOB: Start/Effective Date:

Cost for Employee/Worker coverage only:

Monthly Semi- Monthly Bi-Weekly Weekly

Cost to Employee/Worker to extend coverage for dependents/child:

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Plan Administrator's Name:

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Name: Title:

Date: Phone Number: Email Address: