

# 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: \_\_\_\_\_