

STATE OF WISCONSIN  
EMPLOYER VERIFICATION OF HEALTH INSURANCE

\_\_\_\_TO BE COMPLETED BY THE EMPLOYER \_\_\_\_

**EMPLOYEE, Please return this original (not a copy) to  
State of Wisconsin, P.O. Box 6530, Madison, WI 53716-0530 by:**

EMPLOYER INFORMATION

EMPLOYEE INFORMATION

EMPLOYER: We require major medical health insurance information concerning the employee named above. Please complete this form and return to the employee as soon as possible so s/he can return it by the date above. If you have questions, please call

(Additional instructions are included on the back of this form.)

**HEALTH INSURANCE INFORMATION**

Is the employee listed above currently employed by you?	<input type="radio"/> Yes <input type="radio"/> No
Is this employee now or has s/he, within the last 12 months, been covered under your employer-sponsored major medical health plan?	<input type="radio"/> Yes <input type="radio"/> No
If "Yes", what date did coverage begin?	_____ MM/DD/YY
If coverage has ended, what date did it end?	_____ MM/DD/YY
Which family members are/were covered under the plan? (Please indicate all that apply)	<input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Children <input type="radio"/> Step-children <input type="radio"/> Other
Could this employee enroll in and receive family coverage under an employer-sponsored group health plan in the current month?	<input type="radio"/> Yes <input type="radio"/> No
If "Yes", would the employer pay at least 80% of the premium?	<input type="radio"/> Yes <input type="radio"/> No
Which family members could be covered under this health plan? (Please indicate all that apply)	<input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Children <input type="radio"/> Step-children <input type="radio"/> Other
Will the employee be able to enroll in and receive family coverage under an employer-sponsored group health plan in the next 12 months?	<input type="radio"/> Yes <input type="radio"/> No
If "Yes", what is the date employee will have access?	_____ MM/DD/YY
Does the employer contribute at least 80% of the premium?	<input type="radio"/> Yes <input type="radio"/> No

Signature of the Employer / Designee: _____	Date: _____
Title: _____	Tel: _____
Email: _____	FAX: _____

**For Office use only**

