Verification of Insurance Coverage

City Employee: Please give this form to the Benefits/HR Department of the company/university that provides your current medical coverage. Please complete your name and SSN# prior to requesting information.

Attention: Employer/Agency/University Representative:

The following City of Boise employee has declined insurance coverage; we need verification that he/she has health insurance coverage. Please complete both sections below and send to: **City of Boise Human Resources P. O. Box 500 Boise, ID 83701-0500 or fax to (208)433-5682. If you have questions please call our office at (208)384-3850.**

City of Boise Employee's Name: (to be filled out by employee)	
Social Security Number: (to be filled out by employee)	
Representative's Name	
Title	
Name of Company/Employer/University	
Telephone Number	
Signature	
Date	
Date Employee became eligible for insurance	
Effective Date of Medical Coverage	
Effective Date of Dental Coverage	

I verify that our employee/insured/student:
_____SS#_____ and his/her eligible dependents listed below (if applicable) are covered under our group medical plan.

Dependent Name:	**Relation to Employee/insured/student**	**Date of Birth**