MEMORIAL HERMANN | Health Plan
Medicare *Advantage* Plans
Health Plan Commercial Groups

Employee Verification Form

This form needs to be completed when employees are not listed on the most recent quarterly wage and tax report or other proof of wages documentation. These persons must be listed even if they decline coverage.

Employer Information

Group Name:

Group Address:

Please list below all individuals who meet the following conditions:

- Not listed on your most recent stat wage and tax report
- New employees who work a minimum of 30 hours per work week
- Owners, partners and officers
- Independent contractors (1099 employees)
- Not currently working but covered on the group plan (i.e. state or federal continuation, disability, etc.)

Status Codes: *use the following letter codes to indicate status*

FT: Full-time
PT: Part-time
I: Independent Contractor
O: Owners/Partners, Sole Proprietors
S: Season/Temporary
D: Disabled
C: COBRA/State Continuation
T: Terminated
WP: Full-time in waiting period

Employee Name	Date of Full-time Employment	Hours worked per week	Enrolling in Coverage (Y or N)	Status Code

If additional space is needed, please attach additional pages.

I hereby certify that I have read this document and that the information provided is accurate and complete. I also certify that the information provided here can be substantiated by business records maintained by me. Upon request, I agree to provide the documentation requested by MHHP verifying participation and eligibility requirements. I understand that providing incomplete, inaccurate or untimely information may void, reduce or terminate the group's coverage.

Signature of Employer: _____ Date: _____

Printed Name of Employer: _____ Title: _____

Broker Signature: _____ Date: _____