



## SPECIAL FUND EMPLOYER VERIFICATION FORM FOR HEALTH INSURANCE PREMIUM EXPENSES

\*Name: \_

\*Name and Address of Employer: \_

The above named Employee is enrolled for coverage under the following plan(s):

Type of Plan	Date Coverage Began	Date Coverage Ended	Premium Amount
Health Plan			
Dental Plan			
Vision Plan			
Prescription Drug Plan			
Other (List other health			
care coverage)			

Check one:

The Employer does not allow any employees to pay for their portion of health insurance premiums on a pre-tax basis through a section 125 cafeteria plan.

The Employer maintains a section 125 cafeteria plan under which employees may pay for health insurance premiums on a pre-tax basis.

Contact Person and Telephone # for above-named Employer

Signature of Contact Person

By signing below, I give the Michigan Electrical Employees' Health Plan permission to contact the Employer named above for additional information, if required, about my health plan coverage dates and premium payments.

Employee Signature

Name of Participant Enrolled in Michigan Electrical Employees' Health Plan to which Employee is related:

\*The individual named should be the employee covered under the health plans offered by the Employer listed on this form.

Date

Telephone #

Date