

MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN



SPECIAL FUND EMPLOYER VERIFICATION FORM FOR HEALTH INSURANCE PREMIUM EXPENSES

he above named Employee is enrolled for coverage under the following plan(s):			
Type of Plan	Date Coverage Began	Date Coverage Ended	Premium Amoun
ealth Plan			
ental Plan			
sion Plan			
rescription Drug Plan			
ther (List other health re coverage)			
pre-tax basis through a se	naintains a section 125 cafeteria pla		•
Contact Person and Tele for above-named Emp	ephone #	Telep	ohone #
	ephone # oloyer		ohone #
for above-named Emposition Signature of Contact Poorting y signing below, I give the Micl	ephone # oloyer	Plan permission to contact the E	D ate)