Note: The information requested in the following report may be provided by an employer on its own form, for example, as a computer print out.

(Caption)

HEALTH INSURANCE COVERAGE REPORT

This information must be completed and returned within 15 days. Failure to comply may result in issuance of a subpoena or other appropriate sanctions.

Employee's Name: ________________________

Employee's Social Security #:________________

Does the employer make medical, dental, eye care, prescription or other insurance coverage available to the employee? Yes u **No** u

Name the dependents covered under the employee's insurance, and indicate which types of coverage they have through your company.

		Type of Coverage					
Full Name	**SS #**	**Hospitalization**	**Medical**	**Dental**	**Eye**	**Prescription**	**Other**
____________________		u	u	u	u	u	u
____________________		u	u	u	u	u	u
____________________		u	u	u	u	u	u
____________________		u	u	u	u	u	u
____________________		u	u	u	u	u	u
____________________		u	u	u	u	u	u

Provide the information indicated for each type of insurance which is available to the employee, whether or not any of the above-named dependents are covered at this time:

Insurance company (provider): ____
Group #: ___________ **Plan #:** ___________ **Policy #:** ___________
Effective coverage date: _____________ **Type of coverage:** _____________
Cost of coverage for dependents: __________________________________

Insurance company (provider): ____
Group #: ___________ **Plan #:** ___________ **Policy #:** ___________
Effective coverage date: _____________ **Type of coverage:** _____________
Cost of coverage for dependents: __________________________________

Insurance company (provider): ____
Group #: ___________ **Plan #:** ___________ **Policy #:** ___________
Effective coverage date: _____________ **Type of coverage:** _____________
Cost of coverage for dependents: __________________________________

Insurance company (provider): ____
Group #: ___________ **Plan #:** ___________ **Policy #:** ___________
Effective coverage date: _____________ **Type of coverage:** _____________
Cost of coverage for dependents: __________________________________

If the above-named dependents are not currently covered by insurance, please state the earliest date coverage could be provided. ____________

PLEASE PROVIDE FORMS NECESSARY TO ADD DEPENDENTS, AS THE EMPLOYEE MAY BE ORDERED TO PROVIDE COVERAGE FOR THEM.

I verify that the statements made in this Health Insurance Coverage Information form are true and correct. I understand that false statements herein are made subject to the penalties of 18 Pa.C.S. § 4904 relating to unsworn falsification to authorities.

Date: ____________________________ **Signature:** ____________________________

Title: __________________________________