



EMPLOYMENT VERIFICATION REQUEST

To: _____

Name of Employee: _____ Employee Social Security # _____

Signature of Employee: _____ Date: _____

We would appreciate employment and wage information regarding the employee named above. This is necessary in order to determine his/her eligibility for benefits provided by the HealthLink Program. Please provide the information requested below and return to the above address.

Employee's Job Title: _____

Beginning date of current employment: _____

Average hours worked per week: _____ If temporary, Until: _____

Current rate of pay: _____ Effective Pay Period Ending: _____

Frequency of pay: (circle one) Weekly Bi-Weekly Semi-Monthly Monthly

Other: (provide explanation) _____

Indicate if the employee has access to any of the following benefits through his/her employment (Check all that apply)

___ Credit Union Account(s) ___ Savings Bonds ___ Share/Profit Sharing

___ Medical Insurance ___ Retirement Fund/IRA

___ Mandatory Wage Assignment (Please specify): _____

Please list gross wages, bonuses, tips, commissions, etc. If it is easier for you to provide this in another format, please do so.

Pay Period	Actual Date Paid	Gross Pay

Signature / Title of Person Providing Information Date Telephone