Enrollment Verification Form CONFIDENTIAL

Please call 1-888-564-9669 if you need help filling out this form — ask for Group Member Account Services

Employee name:	Employee Social Security Number:
Employer name:	Employer Identification Number (EIN): ***required***
Payroll contact:	Contact phone number:
Fax number:	Contact email:

Which health benefit plan did the employee enroll in? Plan name/number: ______________________________

Including the employee, who in this family is currently enrolled (or will be enrolled) in your health benefit plan?

List names	*Medical effective date*	*Dental effective date*
1) Employee:		
2) Spouse:		
3) Dependent:		
4) Dependent:		
5) Dependent:		
6) Dependent:		

(Attach an additional sheet of paper if necessary)

Note: FHIAP subsidizes medical, prescription, vision and dental premiums only.

Total **Monthly** medical/prescription/vision/dental cost to *employer* for this family $ ____________________

Monthly amount *employer* contributes to employee coverage (subtract) $ — ____________________

Monthly amount *employer* contributes to family coverage (subtract) $ — ____________________

Monthly amount employee owes to *employer* for coverage =$ ____________________

Does the payroll deduction include any other amounts besides medical, prescription, vision or dental?

❑ Yes ❑ No If yes, how much **per check**? ______________

Insurance deductions taken:

❑ 52 times per year ❑ 48 times per year ❑ 26 times per year ❑ 24 times per year ❑ 12 times per year

❑ Other:____________________Please explain:____

Does the payroll check date reflect the premium for:

❑ prior pay period ❑ same pay period ❑ in advance for next pay period

Please mail or fax completed form to:

FHIAP Attn: MAS Rep:____________________

PO Box 5880

Salem, OR 97304-0880

Toll-free fax: 1-866-843-8936 ● Local fax: 503-378-4678 ● Email: mas.fhiap@state.or.us

Reservation Number:__________________________

442-010 (3/08)