NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Verification of Employment

Name: _____   App. Reg/Case #: _____

Social Security Number: XXX-XX- |___|___|___|___|

Address: _____
STREET

_____   _____   _____
CITY   STATE   ZIP CODE

To be completed by the employer:

I certify that _____ works for me as _____
(WHAT DOES EMPLOYEE DO?)

The employee is paid (check one)   ☐ Weekly   ☐ Two Weeks   ☐ Twice per month   ☐ Monthly

Does the employee have access to New York State Health Insurance (NYSHIP)?   ☐ Yes   ☐ No

Does the employee have dependents enrolled in his/her employer sponsored coverage?   ☐ Yes   ☐ No

Please supply the following information:

Last consecutive weeks	Week 1	Week 2	Week 3	Week 4
Date paid	/ /	/ /	/ /	/ /
Gross pay - *include tips, commissions and bonuses*	$	$	$	$

If no longer employed, date last worked: _____

Business name: _____

Business address: _____
STREET

_____   _____   _____
CITY   STATE   ZIP CODE

Business phone: _____

Employer's name: _____   Title: _____
PLEASE PRINT

Employer's signature: _____   Date: _____