# EMPLOYMENT VERIFICATION REQUEST
Michigan Department of Health and Human Services

**Employee Information: Please Print**

| Name of Employee: | | |
|---|---|---|
| Address: | | Apt #: |
| City: | State MI | Zip Code: |

**Wage and Pay Date Information**

| Employee's first date of employment:<br><br>Type of Employment:<br>☐ Permanent ☐ Temporary | If the employee just started working, date first check will be issued:<br><br>Number of hours this check will include:<br>____ | |
|---|---|---|
| **Number of hours expected to work (check one)**<br>☐ Per week ____________ ☐ Per pay period ________ | **Rate of Pay**<br>☐ Hourly $ ____________<br>☐ Salary $ ____________ | **Employee is paid how often?**<br>☐ Weekly ☐ Bi-weekly<br>☐ Monthly ☐ Semi-monthly |

**Insurance Information**

| Does the employer offer health insurance? | ☐ Yes ☐ No |
|---|---|
| If yes, when is the employee eligible to enroll?? | ____________ |
| What would be the expected start date? | ____________ |
| Has the employee accepted coverage under the health insurance plan? | ☐ Yes ☐ No |
| Which plan(s) will the employee be enrolled? | ☐ Medical ☐ Prescription ☐ Dental ☐ Vision |

**Employer Information**

| Business/Company Name: | Employer Contact Name: | |
|---|---|---|
| Address: | Employer Title: | |
| City: | State: | Zip Code: |
| Email: | Phone Number: | |

**Signature**: By signing this form, I certify the above information is true and complete to the best of my knowledge.

| Employer Signature: | Date |
|---|---|

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