MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

SPECIAL FUND EMPLOYER VERIFICATION FORM
FOR HEALTH INSURANCE PREMIUM EXPENSES

***Name:** _____

***Name and Address of Employer:** _____

_____

The above named Employee is enrolled for coverage under the following plan(s):

Type of Plan	Date Coverage Began	Date Coverage Ended	Premium Amount
Health Plan			
Dental Plan			
Vision Plan			
Prescription Drug Plan			
Other (List other health care coverage) _____			

Check one:

☐ The Employer does not allow any employees to pay for their portion of health insurance premiums on a pre-tax basis through a section 125 cafeteria plan.

☐ The Employer maintains a section 125 cafeteria plan under which employees may pay for health insurance premiums on a pre-tax basis.

_____ _____
Contact Person and Telephone # for above-named Employer — Telephone #

_____ _____
Signature of Contact Person — Date

By signing below, I give the Michigan Electrical Employees' Health Plan permission to contact the Employer named above for additional information, if required, about my health plan coverage dates and premium payments.

_____ _____
Employee Signature — Date

Name of Participant Enrolled in Michigan Electrical Employees' Health Plan to which Employee is related:

_____

*The individual named should be the employee covered under the health plans offered by the Employer listed on this form.