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: _____