Standard Response to Verification of Employment/Income

Employers/Payors will provide requested information normally maintained on current and former Employees/Workers/Independent Contractors. Information listed below is provided if available. If additional information not listed on this form is needed, please contact the Employer/Payor.

Employee/Worker Information

Name: _____ Other Name(s) Used: _____

SSN/TIN: _____ Case ID: _____ Date of Birth: _____

Employment Status: ☐ Employed ☐ Never Worked Here ☐ No Longer Works Here ☐ Unpaid Leave of Absence

Employment Start Date: _____ Employment End Date: _____

☐ Part Time ☐ Full Time ☐ Seasonal (Usual Season Start Date: _____ End Date: _____

Termination Reason: _____ New Employer/Payor: _____

Independent Contractor: ☐ Yes ☐ No

Mailing Address: _____

Residential Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____ Job Title/Occupation: _____

Work Site Address: _____

NOTE: Do not use worksite address for child support correspondence unless it is the Employer/Payor address.

Employer/Payor Information

Legal Name: _____ DBA Name: _____

FEIN (Used to pay unemployment taxes): _____ State Employer ID: _____

Income Withholding for Support Orders (IWOs) Address: _____

Correspondence Address: _____

IWO Contact: _____ Phone Number: _____

Fax Number: _____ Email: _____

Employee/Worker Earnings

Pay Cycle: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

Please provide the average over the past twelve months for:

Hours Worked per Pay Cycle: _____ Rate of Pay/Cycle: _____ Other: _____

Wages per Pay Cycle: _____ Gross: _____ Disposable: _____

Commissions per Pay Cycle: _____ Gross: _____ Disposable: _____

Other Types of Pay: _____ Gross: _____ Disposable: _____

NOTE: Other types of pay in addition to the regular rate of pay/period above.

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Employee/Worker Name: _____ **SSN/TIN:** _____ **Case ID:** _____

Employee/Worker Earnings

Amount of Other Mandatory Withholdings Deducted from the Disposable Earnings Reported Above:

Union Dues: _____ Other (Please Specify): _____

Bonus/Lump Sum Payments: ☐ Yes ☐ No Frequency: _____

Employee/Worker Avg Overtime Disposable Earnings per Past Pay Cycle(s) Over Last Three Months: _____

Total Gross for Last Twelve Months: _____ Number of Tax Exemptions: _____

Name of Tax Exemption Dependents: _____

Any withholdings or IWOs against earnings? ☐ Yes ☐ No

If Yes: Order Number: _____ State: _____ County: _____ Amount Deducted: _____

Employee/Worker Health and Medical Insurance Benefits

Is Health or Medical Insurance Offered? ☐ Yes ☐ No If not available now, when will it be? _____

Note: If answer is yes, please complete Employee/Worker Benefits Addendum beginning on page 3.

Certification

- The records are maintained by the employer/benefit administrator.
- The information in the report was taken from records of the employment, compensation, and benefits of the identified employee/beneficiary.
- The information is maintained in the regular course of business.
- It is the regular course of such business to maintain such information; and
- That a memorandum or record of the information was made at the time of the act, transaction, occurrence, or event, or within a reasonable time thereafter.
- Information on tax withholdings including state and local taxes as well as Federal Insurance Contributions Act (FICA) payroll taxes.

Name: _____ Title: _____

Date: _____ Phone Number: _____ Email Address: _____

Standard Response to Verification of Employment/Income

Employee/Worker Name: _____ **SSN/TIN:** _____ **Case ID:** _____

Employee/Worker Benefits Addendum

Has the employee/worker waived coverage? ☐ Yes ☐ No

Is health insurance available for: ☐ Dependents ☐ Spouse ☐ Ex-spouse

What is the month of open enrollment? _____

National Medical Support Notice Address: _____

Medical Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

Insurance Provider's Phone Number: _____ Fax Number: _____

Email: _____

Policy Group Name/Number: _____ Policy/Contract Number: _____

Is health insurance handled by a union or third party? ☐ Yes ☐ No If yes, provide information below.

Name: _____ Phone: _____

Has Employee/Worker enrolled self? ☐ Yes ☐ No Employee/Worker enrolled dependents? ☐ Yes ☐ No

Individuals covered and start/effective dates [list below]:

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Cost for Employee/Worker coverage only: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Cost to Employee/Worker to extend coverage for dependents/child: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Cost to Employee/Worker for family coverage: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Plan Administrator's Name: _____

Plan Administrator's Address: _____

Plan Administrator's Phone Number: _____ Email: _____

Available Insurance Coverage also includes: (Check all that apply)

☐ Dental ☐ Vision ☐ Prescription ☐ Mental Health ☐ Other (Specify) _____

Employee/Worker Name: _____ **SSN/TIN:** _____ **Case ID:** _____

Dental Insurance

Dental Insurance Provider's Name: _____

Dental Insurance Provider's Address: _____

Dental Insurance Provider's Phone Number: _____ Fax Number: _____

Email: _____

Dental Policy Group Name/Number: _____ Dental Policy/Contract Number: _____

Has Employee/Worker enrolled self? ☐ Yes ☐ No

Employee/Worker enrolled dependents? ☐ Yes ☐ No

Individuals covered and start/effective dates [list below]:

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Cost for Employee/Worker coverage only: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Cost to Employee/Worker to extend coverage for dependents/child: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Cost to Employee/Worker for family coverage: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Plan Administrator's Name: _____

Plan Administrator's Address: _____

Plan Administrator's Phone Number: _____ Email: _____

Employee/Worker Name: _____ **SSN/TIN:** _____ **Case ID:** _____

Prescription Insurance

Prescription Insurance Provider's Name: _____

Prescription Insurance Provider's Address: _____

Prescription Insurance Provider's Phone Number: _____ Fax Number: _____

Email: _____

Prescription Policy Group Name/Number: _____ Prescription Policy/Contract Number: _____

Has Employee/Worker enrolled self? ☐ Yes ☐ No

Employee/Worker enrolled dependents? ☐ Yes ☐ No

Individuals covered and start/effective dates [list below]:

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Cost for Employee/Worker coverage only: _____

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☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Cost to Employee/Worker for family coverage: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Plan Administrator's Name: _____

Plan Administrator's Address: _____

Plan Administrator's Phone Number: _____ Email: _____

Employee/Worker Name: _____ **SSN/TIN:** _____ **Case ID:** _____

Mental Health Insurance

Mental Health Insurance Provider's Name: _____

Mental Health Insurance Provider's Address: _____

Mental Health Insurance Provider's Phone Number: _____ Fax Number: _____

Email: _____

Mental Health Policy Group Name/Number: _____ Mental Health Policy/Contract Number: _____

Has Employee/Worker enrolled self? ☐ Yes ☐ No

Employee/Worker enrolled dependents? ☐ Yes ☐ No

Individuals covered and start/effective dates [list below]:

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Cost for Employee/Worker coverage only: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Cost to Employee/Worker to extend coverage for dependents/child: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Cost to Employee/Worker for family coverage: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

Plan Administrator's Name: _____

Plan Administrator's Address: _____

Plan Administrator's Phone Number: _____ Email: _____

Employee/Worker Name: _____ **SSN/TIN:** _____ **Case ID:** _____

Other Insurance

Type of Insurance: _____

Insurance Provider's Name: _____

Insurance Provider's Address: _____

Insurance Provider's Phone Number: _____ Fax Number: _____

Email: _____

Policy Group Name/Number: _____ Policy/Contract Number: _____

Has Employee/Worker enrolled self? ☐ Yes ☐ No

Employee/Worker enrolled dependents? ☐ Yes ☐ No

Individuals covered and start/effective dates [list below]:

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Name: _____ DOB: _____ Start/Effective Date: _____

Cost for Employee/Worker coverage only: _____

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Cost to Employee/Worker for family coverage: _____

☐ Monthly ☐ Semi- Monthly ☐ Bi-Weekly ☐ Weekly

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Plan Administrator's Address: _____

Plan Administrator's Phone Number: _____ Email: _____

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- Information on tax withholdings including state and local taxes as well as Federal Insurance Contributions Act (FICA) payroll taxes.

Name: _____ Title: _____

Date: _____ Phone Number: _____ Email Address: _____