NEW YORK STATE DEPARTMENT OF HEALTH

Office of Health Insurance Programs

Verification of Employment

Name: _____ App Reg./Case # : _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

For Office Use Only

To be completed by the employer:

I certify that _____ works for me as _____.
(What do you do?)

This employee is paid each (circle one): Week Two weeks Twice per month

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

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

Please supply the following information:

Last consecutive weeks	Date paid	Gross pay – Include tips, commissions and bonuses
1		
2		
3		
4		

If no longer employed, date last worked: _____

Business name: _____

Business address: _____

City: _____ State: _____

Zip: _____ Business telephone: _____

Employer's name (please print): _____ Title: _____

Employer's signature: _____ Date: _____