



Group Health or Dental Insurance Plan

Employment Verification of New Insurance Applicant

This is to verify that (name) _____ was employed by

Employer _____

Tax ID # _____ effective _____, 20 _____ and is regularly scheduled to work a minimum of 30 hours per week (20 hours a week for Dental only) and is actively at work on the permanent payroll AND, (check if applicable)

_____ he or she lost other insurance within the past 30 days due to cancellation of another group plan, the death of a spouse, or the loss of eligibility for other medical insurance due to a change in employment hours or termination of employment of a spouse.

He or she is (check one)

_____ newly employed

_____ became eligible for insurance benefits by an increase in working hours to 30 hours a week effective _____ during the past 31 days & was not employed by my practice or in my office during the 180 days prior to the employment (or new eligibility) date designated above.

_____ had a change in family status (including marriage, divorce, the birth or adoption of a child, or placement for adoption)

Our office has a _____ day probationary or provisional employment period before benefits begin (not longer than 90 days). LCMS may require proof of a written employment policy.

Our entire corporate payroll has _____ fewer than 20 employees, or, _____ 20 or more employees.(check one)

Insurance benefits can begin the _____ day of the month of _____.

Insurance for the employee will be paid for by: _____ the practice _____ the employee. Insurance for any dependents will be paid for by: _____ the practice _____ the employee.

This information is given to the best of my knowledge and belief and is complete and true. No material information has been withheld or omitted and all this information may be used in completing the application for enrollment in the group medical or dental insurance. I understand that this employee is eligible for the Lake County Medical Society insurance plans so long as he or she is employed under the conditions stated above and I comply with the LCMS membership requirements. My office will notify the LCMS promptly, IN WRITING upon the retirement, termination, leave of absence or disability leave of this employee, with the employee's current home address. Failure to notify may result in financial liability for claims paid. (See page 2 of this document for signature line)



Date _____ Signature _____, M.D.

Address _____ City _____ Zip _____

Phone _____ Fax _____

Email _____

This form must be signed by a managing partner or authorized representative and returned to the Lake County Medical Society with the new employee’s completed application for enrollment in the group medical or dental insurance plan.

Please request a current version of our Administrative Policy if you do not have one. It has more details on eligibility for enrollment.

Questions? Tel. 847-482-0222. Fax 847-574-0445 Em: LakeDocs@aol.com
Website: LCMSIllinois.org (Go to the Insurance page.)
Address:
Lake County Medical Society
810 S. Waukegan Road, Suite 104
Lake Forest IL 60045

Any information provided herein that is knowingly false is subject to penalties under the Illinois Health Care Benefits Fraud Act.

EE Verify New Eligibility 11.2011