STATE OF MICHIGAN 15TH JUDICIAL CIRCUIT BRANCH COUNTY	MEDICAL INSURANCE VERIFICATION	CASE NO.

Court address: 31 Division Street, Coldwater, MI 49036 Court telephone no. (517) 279-4314

THIS FORM MUST BE COMPLETED BY YOUR EMPLOYER IF YOU WISH TO BE GIVEN THE CORRECT CREDIT FOR INSURANCE PREMIUMS PAID.

To employer: Please provide the following information.

Employee_____ Social Security No._____

Date hired_____ Hourly Rate of Pay_____

Average number of hours worked each week: _____

Is insurance available: Yes or No (please circle one)
Does employee have coverage: Yes or No (please circle one)

If insurance is available or if the employee has coverage, please provide the following information:

Name of Medical Insurance Company_____

Policy Number _____ Group Number _____

Cost for employee individually_____ Cost for Family or Employee plus_____
How many children are covered_____ Name(s) of children_____
Number of additional individuals covered that are not children_____
Effective Date_____

Name of Dental Insurance Company_____

Policy Number _____ Group Number _____

Cost for employee individually_____ Cost for Family or Employee plus_____
How many children are covered_____ Name(s) of children_____
Number and names of additional individuals covered that are not children excluding employee_____
Effective Date_____

Name of Optical Insurance Company_____

Policy Number _____ Group Number _____

Cost for employee individually_____ Cost for Family or Employee plus_____
How many children are covered_____ Name(s) of children_____
Number and names of additional individuals covered that are not children excluding employee_____
Effective Date_____

Any other health or medical insurance or comments_____

Costs are deducted:[ ] Weekly [ ] Biweekly [ ] Monthly [ ] Bimonthly

Company Name:_____ Completed by_____

Date_____ Phone Number_____

(PLEASE FAX THIS FORM BACK TO (517) 279-5175)