State of Illinois
Department of Human Services

5/7 (Permanent)

Request for Employment Verification - AABD

Date: _____

Re: Employee: _____

Alias: _____

Last 4 Digits of SSN: _____

Address: _____

Case Name: _____

Employer:

I.D. Number: _____

We have been told that you employ(ed) the person shown above. We need information so public assistance benefits are paid correctly. Please complete and return this form in the enclosed envelope.

Employment began: _____ ended: _____ . Number of Hours per week: _____

Employee's address: (if different from above): _____

Has he/she received any financial benefits through your firm other than earnings? ☐ Yes ☐ No

If yes, please identify and give the date of last payment:

Has he/she received any disability benefits through your firm? ☐ Yes ☐ No

If yes, how much? _____

If Yes, please identify and give the date of last payment:

Are earned income credit payments being paid with wages? ☐ Yes ☐ No If Yes, how much? _____

Is/was employee covered by your health plan?

☐ Yes -- Complete the HEALTH INSURANCE REPORT on the reverse.

☐ No - Complete #2B on the reverse.

Reason for termination: _____

Do you plan to rehire? _____ If so, when? _____

Please provide pay information on an individual pay period basis for the period of _____

through _____

Pay Period Ending	Date Paid	Gross Pay	Tips	F.I.C.A	Federal Withholding	State Withholding	Union Dues	Savings Bonds/ Credit Union/Other (specify)

Employer's completion of this form or compliance with instructions is voluntary. However, failure to do so may affect this Department's action.

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Health Insurance Report

1. Case Name: _____

Case Number: Cat. _____ L.O. _____ Group: _____ Basic: _____

2a.Policy Holder/Employee Last, First and MI: _____

Date of Birth: _____

INSURANCE BEGIN DATE: _____ INSURANCE END DATE: _____

2b. ☐ Check if employee is not covered by a group health plan through your organization.

Employee may enroll on _____ .

Check if health insurance is available at no cost to ☐ employee or ☐ dependents

3. Complete for insurance through Employer/Union

Employer/Union: _____ Union Local #: _____

Street: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Group: _____

Certificate/Policy Number: _____

4. Where Are Claims Mailed?

Medical Claims to - Name _____

Street: _____

City: _____ State: _____ Zip: _____

Prescription Drug Claims to - Name: _____

Street: _____

City: _____ State: _____ Zip: _____

5. Check all the Following Benefits that are Provided

☐ MAJ Med ☐ Dental ☐ Vision ☐ LTC ☐ RX Drug RX Card #: _____

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6. Complete for Employee and Dependent Coverage

Last Name First Name	Recipient Number (DHS Use Only)	Date of Birth	Insurance Begin Date	Insurance End Date	*

*ENTER RELATIONSHIP TO POLICYHOLDER CODE (POLICYHOLDER-0, SON-1, DAUGHTER-2, SPOUSE-3, STEPCHILD-4, GRANDCHILD-5, OTHER-6)

7. Complete if person in #6 were insured by you under a previous plan.

Name of Previous Carrier: _____ Group Number: _____

Begin Date: _____ End Date: _____

Street: _____

City: _____ State: _____ Zip: _____

8. Completed By:

Signature _____

Telephone Number: _____ Date: _____

9. DHS USE ONLY: SEND PHOTOCOPY OF COMPLETED FORM TO THIRD PARTY LIABILITY, BUREAU OF COLLECTIONS.

Check One ☐ ORIGINAL ☐ UPDATE CHECK

☐ IF TPL IDENTIFIED THROUGH DATA EXCHANGE - CROSSMATCH OR ICL CODE: _____

Worker: _____ REMARKS: (IDENTIFY LIMITED POLICY, REASON FOR UPDATE, ETC.)

Date: _____ _____

FRC: _____ Referring Office (if not Local Office): _____

CENTRAL OFFICE USE ONLY ☐ OLD TPL ☐ RDB ☐ CDB

Local Office Stamp

Print Form Reset Form

Employer's completion of this form or compliance with instructions is voluntary. However, failure to do so may affect this Department's action.