



**EMPLOYEE REQUEST FOR MEDICAL INSURANCE ENROLLMENT
CONFIRMATION FOR VESTING PURPOSES**

AS545

Request Date _____

Employee _____ SSN _____

List other names primary insurance
may have been carried under. _____

Ex: maiden or spouse's name

Approximate Dates of Coverage

Complete "Dependent" section only if confirmation is desired on the dependent(s).

Dependent's Name	Dependent's SSN	Approximate Dates of Coverage

Reason for Request: 2 Years until Retirement Agency Transfer Other *

Distribution of Information:

Send to Department _____; Attn _____

Mail to _____

This will be picked up. Call _____ when available.

* A \$25 administrative fee must be paid in advance if confirmation is requested for any reason other than Retirement or Agency Transfer. Research will not commence until payment has been received.

Employee's Signature _____ Date _____

Note: The Payroll Office will provide the requested information as quickly as possible but a definite turnaround time cannot be predicted due to the complex nature of the research required. Requests will be completed in order of receipt, unless the information is needed to complete an immediate retirement.

FOR ACCOUNTING SERVICES USE ONLY

Mailed by _____ on _____ Sent to department

Picked up by _____ on _____