

**TEXAS HEALTH INSURANCE POOL
EMPLOYMENT VERIFICATION FORM**

Copies of this form are to be completed by you and your current employer and your spouse's current employer (even if your spouse is not covered or to be covered by the Pool). If the applicant/member is a child under the age of 25 and single, the current employer of each of the applicant/member's parents and step-parents (as applicable) must complete this form.

Individual's Information (SECTION A)	
Applicant/Member Name:	Applicant/Member Social Security Number or Unique ID
	Spouse's or Parent's Name (if applicable):
Your Signature	Date
Employer Information (To be completed and signed by current Employer only) (SECTION B)	
Employer/Business Name:	Telephone Number:
Address:	Number of Employees (including owner if employed):
Employee's Name:	
Date of Employee Hire or Business Start Date:	Waiting Period for Employer Health Coverage (if any):
How many hours a week does the employee usually work for your business?	
Do you provide group health benefit coverage, either insured or self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If insured, the name of the insurance company: Is coverage available for dependents of the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the person, named above as the applicant/member, eligible for your coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:	
Do you pay all or part of the cost of employee coverage for any employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, can the employee use the amount paid for any other purpose? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate the other permissible uses:	
Do you pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section B Continued on Other Side

If you do not currently provide coverage, was coverage provided during the last 12 months? Yes No

Date of and reason for coverage cancellation/termination:

If insured, the name and telephone number of insurance company:

Do you intend to provide health coverage for employees in the next 6 months? Yes No

Are you working with an agent or third party administrator to secure or establish group coverage? Yes No

If yes, the name and telephone number of the agent or the TPA:

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.

Employer's Signature: _____

Title: _____

Date: _____

Printed Name: _____

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Individual's Information (SECTION A)	
Applicant/Member Name:	Applicant/Member Social Security Number or Unique ID
	Spouse's or Parent's Name (if applicable):
Your Signature	Date
Employer Information (To be completed and signed by current Employer only) (SECTION B)	
Employer/Business Name:	Telephone Number:
Address:	Number of Employees (including owner if employed):
Employee's Name:	
Date of Employee Hire or Business Start Date:	Waiting Period for Employer Health Coverage (if any):
How many hours a week does the employee usually work for your business?	
Do you provide group health benefit coverage, either insured or self-insured? <input type="checkbox"/>Yes <input type="checkbox"/>No If insured, the name of the insurance company: Is coverage available for dependents of the employee? <input type="checkbox"/>Yes <input type="checkbox"/>No Is the person, named above as the applicant/member, eligible for your coverage? <input type="checkbox"/>Yes <input type="checkbox"/>No If no, please explain:	
Do you pay all or part of the cost of employee coverage for any employees? <input type="checkbox"/>Yes <input type="checkbox"/>No If yes, please explain: If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? <input type="checkbox"/>Yes <input type="checkbox"/>No If yes, can the employee use the amount paid for any other purpose? <input type="checkbox"/>Yes <input type="checkbox"/>No If yes, please indicate the other permissible uses:	
Do you pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)? <input type="checkbox"/>Yes <input type="checkbox"/>No	

Section B Continued on Other Side

If you do not currently provide coverage, was coverage provided during the last 12 months? Yes No

Date of and reason for coverage cancellation/termination:

If insured, the name and telephone number of insurance company:

Do you intend to provide health coverage for employees in the next 6 months? Yes No

Are you working with an agent or third party administrator to secure or establish group coverage? Yes No

If yes, the name and telephone number of the agent or the TPA:

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.

Employer's Signature: _____

Title: _____

Date: _____

Printed Name: _____

**TEXAS HEALTH INSURANCE POOL
SELF-EMPLOYMENT VERIFICATION FORM**

Individual's Information (SECTION A)	
Applicant/Member Name:	Applicant/Member Social Security Number or Unique ID
	Spouse's Name (if any):
Employment Information for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	
Business Information (SECTION B)	
Employer/Business Name:	Telephone Number:
Address:	
How long have you been self-employed?	How many hours a week do you usually work?
Do you have any full time employees (work 30 hours per week or more)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, how many?	
Do you provide group health benefit coverage, either insured or self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If insured, the name of the insurance company: _____	
Do you pay all or part of the cost of employee coverage for any employees other than yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:	
If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, can the employee use the amount paid for any other purpose? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please indicate other permissible uses:	
Does the employer pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you intend to provide health coverage for employees in the next 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you working with an agent or third party administrator to secure or establish group coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, the name and telephone number of the agent or the TPA:	
I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.	
Employer's Signature: _____	Title: _____
Date: _____	Printed Name: _____

Another copy of this form is provided on the other side.
Both sides are only required if more than one person is self-employed.

**TEXAS HEALTH INSURANCE POOL
SELF-EMPLOYMENT VERIFICATION FORM**

Individual's Information (SECTION A)	
Applicant/Member Name:	Applicant/Member Social Security Number or Unique ID
	Spouse's Name (if any):
Employment Information for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	
Business Information (SECTION B)	
Employer/Business Name:	Telephone Number:
Address:	
How long have you been self-employed?	How many hours a week do you usually work?
Do you have any full time employees (work 30 hours per week or more)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, how many?	
Do you provide group health benefit coverage, either insured or self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If insured, the name of the insurance company: _____	
Do you pay all or part of the cost of employee coverage for any employees other than yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:	
If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, can the employee use the amount paid for any other purpose? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please indicate other permissible uses:	
Does the employer pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you intend to provide health coverage for employees in the next 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you working with an agent or third party administrator to secure or establish group coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, the name and telephone number of the agent or the TPA:	
I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.	
Employer's Signature: _____	Title: _____
Date: _____	Printed Name: _____

Another copy of this form is provided on the other side.
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