Current Health Insurance Validation

Employee name (please print) _____

List Employee and/or Dependents that are **not** currently enrolled in Escambia County Health insurance:

Please print the following information

Full legal name	SSN	Date of Birth	Gender	Relationship to Employee	Name of Health provider	Type of Insurance (see below)	Effective date of insurance

**Types of Insurance PPO, HMO, HSA, Major Medical, Medicare A & B, Individual or Other (please specify)

Please remember to attach a copy of the current health insurance ID card!

Employee Signature _____ Date _____

HR 12/17/2010