IOWA DEPARTMENT OF HUMAN SERVICES

EMPLOYER INSURANCE NOTIFICATION

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Date Prepared: ______________
Case Number: ______________

Employee Name: ___________________
Soc Sec Number: ___________________

Dear Employer:

We learned that the employee listed above is no longer working for your company. Please provide us with the following information about the health insurance that covered the employee's children:

- The employee's last date of employment.
- The date the health insurance ended (or will end).

Employment end date: __________________________
Policy end date: __________________________
Is the employee continuing health insurance coverage? ___ Yes ___ No

If yes, please check the type of coverage:

___ COBRA ___ Union agreement ___ An agreement with the employer

___ Paying own premium ___ Other

Who can we contact if we have questions about the health insurance?

Name: ____

Insurance Company: ____

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Phone Number: ____

Please return this form to the address provided below **within ten days**.

Employers Partnering in Child Support
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