

TO:

Employer	Street Address	City	State	Zip Code
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RE:

Employee's Name	SSN
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Dear Employer:

Please complete the attached *Employer's Statement of Earnings* for the employee named above. The employee has signed this form, authorizing you to release the information needed. Complete these sections:  Beginning Income  Ending Employment  Health Insurance Benefits. If you need additional space for your response, please attach a separate piece of paper.

Please sign and return all copies of the form by \_\_\_\_\_. We have provided a postage-paid return envelope for your use. If you have any questions, please contact me at \_\_\_\_\_. Thank you in advance for your prompt attention to this request.

\_\_\_\_\_ Income Maintenance Worker

Iowa Department of Human Services

### EMPLOYER'S VERIFICATION OF EARNINGS

Worker Name	
Worker Phone No.	County

Please return all copies of this form by:

Case # \_\_\_\_\_

I authorize my employer, former employer, or insurance carrier named below to furnish the **Iowa Department of Human Services** any confidential information requested regarding my employment or insurance coverage. I forever release and discharge my employer, former employer, or insurance carrier from any liability for divulging this information. This authorization expires 60 days after the date of my signature.

Employee Last Name	First	MI	SSN	Employee Signature	Date
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Employer Name	Address	City	State	Zip Code
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<input type="checkbox"/> <b>BEGINNING EMPLOYMENT</b>		<input type="checkbox"/> <b>HEALTH INSURANCE BENEFITS</b>																						
<b>Beginning date of employment</b> _____ <b>Date first check received</b> _____		Do you offer health insurance to your employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, STOP HERE. If yes, complete the following questions:																						
Current rate of pay: \$ _____ per <input type="checkbox"/> hour <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year Frequency of pay: <input type="checkbox"/> weekly <input type="checkbox"/> biweekly <input type="checkbox"/> monthly <input type="checkbox"/> semimonthly <input type="checkbox"/> other - explain _____ Day of week pay period ends on: _____ Paid _____ days later on _____ (day of week)		<b>Date employee is eligible to enroll:</b> _____  What is cost to the employee, if any, for premiums?																						
Hours of work per week _____ Avg. hours of overtime per week _____		<table border="1"> <thead> <tr> <th>PLAN OPTION</th> <th>COST</th> <th>PER (check only one)</th> </tr> </thead> <tbody> <tr> <td>Employee</td> <td>\$ _____</td> <td>weekly <input type="checkbox"/> 52 or <input type="checkbox"/> 48 x yearly</td> </tr> <tr> <td>Employee/Spouse</td> <td>\$ _____</td> <td>biweekly <input type="checkbox"/> 26 or <input type="checkbox"/> 24 x yearly</td> </tr> <tr> <td>Employee/Children</td> <td>\$ _____</td> <td><input type="checkbox"/> semimonthly</td> </tr> <tr> <td>Family</td> <td>\$ _____</td> <td><input type="checkbox"/> monthly</td> </tr> <tr> <td>Dental</td> <td>\$ _____</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td>Other option</td> <td>\$ _____</td> <td>(Explain) _____</td> </tr> </tbody> </table>		PLAN OPTION	COST	PER (check only one)	Employee	\$ _____	weekly <input type="checkbox"/> 52 or <input type="checkbox"/> 48 x yearly	Employee/Spouse	\$ _____	biweekly <input type="checkbox"/> 26 or <input type="checkbox"/> 24 x yearly	Employee/Children	\$ _____	<input type="checkbox"/> semimonthly	Family	\$ _____	<input type="checkbox"/> monthly	Dental	\$ _____	<input type="checkbox"/> Other	Other option	\$ _____	(Explain) _____
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Dental	\$ _____	<input type="checkbox"/> Other																						
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Does employee receive tips? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimated tip income \$ _____		Is this a cafeteria plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Is employee currently enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No																						
Does employee receive commissions? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimated commission income \$ _____		Are employee's dependents currently enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No																						
<input type="checkbox"/> <b>ENDING EMPLOYMENT</b>		Name/Address of Insurance Company _____																						
Last date of employment _____ Date final check received _____ Gross amount \$ _____		PLEASE ATTACH A COPY OF THE POLICY OR BENEFITS PLAN.																						
Reason for termination: <input type="checkbox"/> Quit <input type="checkbox"/> Fired <input type="checkbox"/> Laid off Comments: _____																								
Is employee eligible for COBRA or other continuation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No																								
Is job still available? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date job was filled: _____		Would you rehire this person? <input type="checkbox"/> Yes <input type="checkbox"/> No																						

Please list the gross amount of each payroll check RECEIVED or anticipated to be received in each month beginning in \_\_\_\_\_ through \_\_\_\_\_. ANTICIPATED INCOME NEED ONLY BE AN ESTIMATE. Attach a separate page if more space needed.

Date pay period ends	Date pay received	* Gross amount	Hours worked
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\* Is any of the gross amount Earned Income Tax Credit  Yes  No If Yes, Amount \_\_\_\_\_

Employer/Representative Signature	Title	Phone	Date
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