REQUEST FOR PROOF OF COVERAGE

(January 1, 2024 through December 31, 2024)

Confirmation of proof of coverage/enrollment for: _____

Section 1: Medical Insurance Coverage Verification

☐ Does Not Have Coverage (skip to Section 2)

☐ Has Coverage (please provide additional information):

Name of Insurance Company:	
Name of Policy Holder:	Subscriber ID:
Covered Dependent(s) & Relationship to Policy Holder:	
Effective Date of Coverage:	
Coverage Estimated to Last Until 12/31/2024? ☐ Yes ☐ No - Estimated to End:	
Is this coverage considered "Group Coverage," not purchased on the individual market (including through Covered California), and meets the standards of affordable, minimum value coverage as defined by the Affordable Care Act?	☐ Yes ☐ No

Section 2: Dental Insurance Coverage Verification

☐ Does Not Have Coverage (skip to Section 3)

☐ Has Coverage (please provide additional information):

Name of Insurance Company:	
Name of Policy Holder:	Subscriber ID:
Covered Dependent(s) & Relationship to Policy Holder:	
Effective Date of Coverage:	
Coverage Estimated to Last Until 12/31/2024? ☐ Yes ☐ No - Estimated to End:	

Section 3: Employer/Benefits Representative

By my signature below, I hereby confirm the above is true and correct.

Signature _____ Printed Name _____ Date _____

Title _____ Company Name _____

Phone _____ Email Address _____

PLEASE COMPLETE AND SEND TO: HRBENEFITS@SANTA-ANA.ORG OR FAX (714) 647-6930