

# Employer Certification of Participant Status

To be completed by employer

## EMPLOYER INFORMATION

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Employer name: \_\_\_\_\_ Church code: \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_ Fax number: (\_\_\_\_\_) \_\_\_\_\_

Employer Tax ID number (EIN): \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer's physical address: \_\_\_\_\_

Billing address if different from the employer's physical address

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

For Medicare reporting please indicate the number of full-time and part-time employees currently on the payroll:

1-19 employees     20-99 employees     more than 100 employees

According to the Patient Protection and Affordability Act we are required to know how much the employee is required to pay for their insurance premiums. If the amounts listed below change, you are required to inform Alliance Benefits.

Employee pays percentage of premiums \_\_\_\_% employee \_\_\_\_% employer     Employee pays fixed amount of \$ \_\_\_\_\_ for premiums

## EMPLOYEE VERIFICATION

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Employee first name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security number (last four digits): \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of full-time employment: \_\_\_\_/\_\_\_\_/\_\_\_\_ Coverage effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Total annual salary: \_\_\_\_\_ (needed for Life and Disability Insurance) Occupation: \_\_\_\_\_

The undersigned employer representative confirms that this applicant is a paid employee of the above named organization, working 20 or more hours per week, and that the reported salary is accurate. We understand that the addition of the coverage being requested by this applicant, upon approval, will be added to our employer's monthly billing statement. **(The employer representative cannot be the applicant.)**

Signature of authorized employer representative: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Title: \_\_\_\_\_ Contact phone: (\_\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

**Return completed form to:** Alliance Benefits  
PO Box 35690  
Colorado Springs, CO 80935-3569

**Or fax to:** 719-262-5397

For more information or eligibility rules go to [www.alliancebenefits.org](http://www.alliancebenefits.org)



**ALLIANCE  
BENEFITS**  
Compassion. Integrity. Respect.