REQUEST FOR EMPLOYMENT INFORMATION

From:	Telephone No.
Social Security Administration	
Employer's Name and Address	Date:
	Employee's Name:
	Employee's Social Security Number:
	Claimant's Name:
	Claim Number:
Dear Sir/Madam:	
We need the following information regarding the above claimant. Please answer the questions below, sign and date this letter and return it in the enclosed envelope.	
•	at the above telephone number if you have
any questions.	Sincerely,
	Office Manager
1. Is (or was) the claimant covered under ar	Employer Group Health Plan?
Yes No _	
2. If yes, give the original date the coverage began (mm/yyyy)	
3. Has the coverage ended? Yes	No
4. If yes, give the date the coverage ended.	(mm/yyyy)
5. When did the employee work for your con	mpany?
From(mm/dd/yyyy)	To Still Employed
Signature and Title of Company Official	Date Telephone Number

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0787. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.