Employee Health Insurance Form

Employee Information:

- **Employee Name: _____**
- **Employee ID: _____**
- **Department: _____**
- **Position/Job Title: _____**
- **Phone Number: _____**
- **Email Address: _____**

Employer Information:

- **Company Name: _____**
- **Company Address: _____**
- **Employer Contact Person: _____**
- **Phone Number: _____**
- **Email Address: _____**

Health Insurance Details:

- **Plan Name: _____**
- **Policy Number: _____**
- **Coverage Start Date: _____**
- **Dependent Coverage: [ ] Yes [ ] No**
    - **If Yes, List Dependents: _____**

Signature of Employee: _____

Date: _____