Group Coverage Eligibility Verification Letter

Date: _____

To: _____

Company Name: _____

Group Number: _____

This letter is to verify the eligibility of the following individual(s) for group health insurance coverage under the above-mentioned policy:

Employee Name: _____

Employee ID: _____

Coverage Start Date: _____

Coverage Type: _____

If you require additional information, please contact our office.

_____

Authorized Representative

Title: _____

Contact Number: _____

Email: _____