FORM APPROVED
OMB NO. 0938-0787

REQUEST FOR EMPLOYMENT INFORMATION

From: **Social Security Administration**	Telephone Number:
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.

You may call _____ at the above telephone number if you have any questions.

Sincerely,

Office Manager

1. Is (or was) the claimant covered under an 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 company?
   From _____ (mm/yyyy) To _____ (mm/yyyy) Still Employed _____ (mm/yyyy)

Signature and Title of Company Official	Date	Telephone Number