Verification of Health Coverage

Verification of ***eligibility*** for other creditable health coverage is required for Tyson Foods team members and their dependents covered under the Tyson Group Health Plan. Please complete this form and return to your employee.

Name of Individual Requesting Verification (Last, First, M.I.):		Date of Verification:
Name of Tyson Foods Team Member:	Team Member Personnel Number:	Relationship: ☐ Self ☐ Spouse ☐ Dependent Child
Name of Health Plan:	If Self-Employed, health plan coverage through my employment: ☐ Is offered ☐ Is **NOT** offered	
Effective Date of Participation:	Effective Through Date:	

If coverage is through Employer:

Employer Name:	
Employer Address, City, State and Zip Code:	
Employer Telephone Number:	Employer Contact Name:
☐ Employer does **NOT** offer health plan coverage. ☐ Employee is currently **NOT** eligible for health plan coverage. Date eligible to enroll:	

I understand providing a fraudulent or intentionally misleading representation could result in a rescission of coverage, as described in the Group Health Plan Summary Plan Description.

Signature of Employer's Authorized Representative

Date

Revised 08/17