OK Employer Services Center P.O. Box 248805 Oklahoma City, OK 73124-8805 State of Oklahoma
Oklahoma Department of Human Services
Oklahoma Child Support Services
(405) 522-5550 Oklahoma City Area
(866) 553-2368 Toll Free
(405) 522-5555 Fax Number
www.OKDHS.org

RE:	[Employee Name]	
AP#:	[OCSS Identifying Number]	
SSN:	[Employee Social Security Number]	
DOB:	[Employee Date of Birth]	

The Oklahoma Department of Human Services is attempting to verify employment for the above named individual regarding child support obligations as authorized by Title 56, §237 (B) (5) of the Oklahoma Statutes. Insurance information is also being requested from employers pursuant to Federal Regulations at 45 CFR 303.30 and 45 CFR 303.31.

Available information indicates your employee records might be of assistance. Please compare the information listed below with your records. If the information is the same, please indicate with a check mark and if incorrect or missing please enter the correct information in the space provided. Also, complete the back of this form concerning medical insurance coverage for children of your employee.

We would appreciate receiving your response within twenty (20) days. Your cooperation will help to conserve tax dollars needed to fund state programs and prevent dependence on welfare programs in the future.

If you have questions concerning this request, contact the office at the telephone number shown above. Thank you for your time and cooperation.

As Known by OKDHS	Employer Records
Name:	
Job Title:	
Address:	
SSN: DOB: State Employer ID No.(EIN) Federal Employer ID No.(FEIN)	
Dates of Employment: From:	To:
Salary:()Hourly	()Weekly ()Semi-Monthly ()Monthly
Shift Worked:	

State of Oklahoma Oklahoma Department of Human Services Oklahoma Child Support Services Employee Medical Insurance Survey

SSI	N:		
(Employee Name) NCI	NCP NO.:		
Mailing Address (Street)	(City) (St	tate) (ZIP Code)	
Is this person currently employed by your company? If no, please give termination date:	()YES (
Reason:			
2. Is medical insurance coverage available to you through	n your compar ()YES No	•	
Are medical benefits being provided under the federal I (ERISA) of 1974?	Employee's R ()YES (
Note: If more than one insurance policy is involved form and complete items 5 through 9 for each insurance c		nedical coverage, copy t	
 Medical insurance coverage is available for this employ () Children () Spouse () Ex-spouse 	/ee's		
5. Cost to employee for dependent coverage per pay peri () Weekly ()Bi-Weekly ()Semi-Monthly ()			
Please list the persons currently enrolled			
Name	DOB	SSN	
Types of Coverage: (Check all that apply) Medical() Prescriptions () Vision () Mental Health () Hospit Hospitalization-inpatient () Accidental Coverage () Hospital ONLY () PPO () Other()	al Surgery É Dread Diseas	() se ()	
Name of Insurance Company:			
Policy Number: Group Name			
Group Policy Number:			
Policy Holder Name:			
Policy Holder Social Security Number:			
Coverage Begin Date: Coverage	ge End Date:		

Policy Renewal Date:				
Insurance Policy Deductible Amount:	5			
Address				
City	State	Z	IP	
Please correct your business information	if it is different from th	ne front page) .	
Employer Name:				
State Employer ID Number: (EIN)				
Federal Employer ID Number: (FEIN)				
Employer Address:				
(Location Address)		City	State	ZIP
(Delivery Address)		City	State	ZIP
		•		
(Print name of person completing form)	T			
(Signature)	(Date)			
Phone No.()	_ Fax No.()			