BlueCross BlueShield of Texas

An Independent Licensee of the Blue Cross and Blue Shield Association

TEXAS SUPPLEMENTAL EMPLOYMENT VERIFICATION

To be used with the TWC Report

Employer's Name	SIC Code	Group Policy Number

Address	City	State	Zip

EMPLOYEE CENSUS INFORMATION

Under our Small Group Employer products, BCBSTX verifies employment information. **We require the submission of a current TWC Report.** The TWC Report is used to verify the SIC Code applicable to your company and to assist us in verifying employment. Please utilize the status codes listed below to denote the employment status of all employees listed on your TWC Report. Employees who are not indicated on the TWC Report should be reported using this Supplemental Employment Verification Form. All full-time employees must complete a BestChoice Application indicating (1) they are requesting coverage or (2) they are declining coverage. Applications for individuals requesting coverage cannot be processed without verification of employment. If this information is missing, the effective date of coverage may be delayed.

STATUS CODES

Please use the appropriate code indicating applicable status of the person listed on the TWC Report or this form:

F	Full-time employee who works 30 or more hours per week
P	Part-time employee who works less than 30 hours per week
I	Independent contractor working 30 or more hours per week
O	Owners, Partners and Officers who work 30 or more hours per week
D	Totally disabled employee
C	Continued employee under State or Federal law
T	Terminated employee no longer employed by the company
W	Full-time employees in Waiting Period

EMPLOYEES NOT LISTED ON THE TWC REPORT

Please list the following persons employed by you:

- New employees who do not appear on your TWC Report and work a minimum of 30 hours per week
- Owners, Partners and Officers who work a minimum of 30 hours per week
- Independent contractors who work a minimum of 30 hours per week
  (List only if offering coverage. It is not necessary for you to offer coverage to Independent Contractors; however, you must offer coverage to all Independent Contractors who work for you if you wish to cover any Independent Contractors.)
- Other
  (Please define employees who fall into this category so BCBSTX may determine if they are eligible for coverage.)

These Persons Must Be Listed Even If They Decline Coverage

	NAME	DATE OF FULL-TIME EMPLOYMENT	HOURS WORKED PER WEEK	STATUS CODE	APPLYING FOR COVERAGE (YES) DECLINING COVERAGE (NO) ATTACH APPLICATION
1					☐ Yes ☐ No
2					☐ Yes ☐ No
3					☐ Yes ☐ No
4					☐ Yes ☐ No
5					☐ Yes ☐ No
6					☐ Yes ☐ No
7					☐ Yes ☐ No
8					☐ Yes ☐ No
9					☐ Yes ☐ No
10					☐ Yes ☐ No
11					☐ Yes ☐ No
12					☐ Yes ☐ No
13					☐ Yes ☐ No
14					☐ Yes ☐ No
15					☐ Yes ☐ No
16					☐ Yes ☐ No
17					☐ Yes ☐ No
18					☐ Yes ☐ No
19					☐ Yes ☐ No
20					☐ Yes ☐ No
21					☐ Yes ☐ No
22					☐ Yes ☐ No
23					☐ Yes ☐ No
24					☐ Yes ☐ No
25					☐ Yes ☐ No

I HEREBY CERTIFY I HAVE READ THIS DOCUMENT AND THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE. I ALSO CERTIFY THE INFORMATION PROVIDED HERE CAN BE SUBSTANTIATED BY BUSINESS RECORDS MAINTAINED BY ME. UPON REQUEST, I AGREE TO PROVIDE THE DOCUMENTATION REQUESTED BY BCBSTX VERIFYING PARTICIPATION AND ELIGIBILITY REQUIREMENTS. I UNDERSTAND PROVIDING INCOMPLETE, INACCURATE, OR UNTIMELY INFORMATION MAY VOID, REDUCE OR TERMINATE THE GROUPS COVERAGE.

Signature of Authorized Company Official _____ Title _____ Date _____

Print Name of Authorized Company Official _____

Signature of Agent _____

BCBSTX does reserve the right to randomly request documents verifying the above information. In addition, we reserve the right to reverify employment information at any time during the course of your contract with us.