

Proof of Insurance Form



*Employer Name: _____

*Employee Name: _____

*Social Security Number: _____ *Birthday: _____

*Street Address: _____

*City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

Work Phone: _____ Mobile/Cell Phone: _____

Insurance Carrier: _____

Month you are providing Proof of: _____

Monthly amount of Premium: _____

NOTE: This form is to provide proof of insurance only to Febco, Inc. You must submit the proof of insurance and a Medical Reimbursement Request Form to be reimbursed.

Employee Signature: _____ Date: _____

If you have questions, feel free to call **Febco, Inc.** toll-free 1-800-489-1539.

Customer Service is available to assist you, Monday through Friday, 8:00 A.M. until 4:30 P.M., Eastern Time.

Please fax this form to: 502-695-9692