Commonwealth of the Northern Mariana Islands
Office of the Attorney General
2nd Floor Hon. Juan A. Sablan Memorial Bldg.
Caller Box 10007, Capitol Hill
Saipan, MP 96950

EDWARD MANIBUSAN
Attorney General

LILLIAN A. TENORIO
Deputy Attorney General

Standard Response to Verification of Employment

Employers will provide requested information normally maintained on employees. If additional information not listed on this form is needed, please contact the employer.

PAYROLL SECTION – Employee Personal Information

Full Name: _____
Last First M.I.

Residential Address,
If known: _____
Street Address Apartment/Unit#
_____
City State Zip Code

Mailing Address,
If known: _____
Street Address Apartment/Unit#
_____
City State Zip Code

Home Phone: _____ Alternate Phone: _____

E-mail Address, if known: _____

Social Security Number: _____ Date of Birth: _____

Employer and Job Information

Employment Status: Current Employed Terminated Never Employed

Title: _____ Dates of Employment: _____

Employer Name: _____ Employer Address: _____

Employer Phone Number: _____ Employer Fax Number: _____

Federal EIN: _____

Full/Part Time or Seasonal: Full Time Part Time Seasonal Begin Date: _____ End Date: _____
Return to Work Date: _____

Employee Work Site or Location: _____

Termination Reason: Voluntary Involuntary

Wage Information

Pay Cycle/Frequently: _____ Rate of Pay: $_____

Gross Pay Per Period: $_____ Net Disposable Pay Per Period: $_____

Current Year-to-Date Earnings: $_____

Previous Calendar Year Earning: $_____

Union Name: _____ Local Number: _____

Mandatory Union Dues: $_____ Mandatory Retirement: $_____

Tax Filing Status: Single Married Head of Household

Number of Dependents: _____

Workers' Compensation: Yes No

Name of Workers' Compensation
Company and Contact Information: _____

_____

Certification Information

Name of Employer: _____

Name: _____

Title: _____

Signature: _____

Date: _____ Phone Number: _____ Cell Number: _____

If additional information is needed, please contact the person listed above

HEALTH INSURACE SECTION – Employee Personal Information

Full Name: _____
Last First M.I.

Last 4 digits of Social Security Number_____

Civil Division
Telephone: (670) 237-7500
Facsimile: (670) 664-2349

Criminal Division
Telephone: (670) 237-7600
Facsimile: (670) 234-7016

Attorney General's Investigation Division
Telephone: (670) 237-7627
Facsimile: (670) 234-7016

Victim Witness Advocacy Unit
Telephone: (670) 237-7602
Facsimile: (670) 664-2349

Health Insurance Availability

Does the employer offer health insurance? Yes No

If not available currently to the employee, when will it be available? _____

Is health insurance available for dependents or spouse: Yes No

Previous Calendar Year Earning: $_____

Is this paid by: Payroll Deduction Payment

Has the employee enrolled self and/or dependents: Self Dependents

Does the employer offer health insurance? Yes No

If not available currently to the employee. When will it be available? _____

Is health insurance available for dependents or spouse: Yes No

Previous Calendar Year Earnings: $_____

Is this paid by: Payroll Deduction Payment

Has the employee enrolled self and/or dependents: Self Dependents

Medical Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: _____

Policy Group Name/Number: _____ Cost for Listed Children: $_____

Cost for Employee/Family: $_____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Civil Division
Telephone: (670) 237-7500
Facsimile: (670) 664-2349

Criminal Division
Telephone: (670) 237-7600
Facsimile: (670) 234-7016

Attorney General's Investigation Division
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Facsimile: (670) 234-7016

Victim Witness Advocacy Unit
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Facsimile: (670) 664-2349

Dental Insurance

Insurance Provider's Name:_____

Insurance Provider's Address:_____

_____

Insurance Provider's Phone: Insurance _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: _____

Policy Group Name/Number: _____ Cost for Listed Children: $_____

Cost for Employee/Family: $_____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Vision Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $_____

Policy Group Name/Number: _____ Cost for Listed Children: $_____

Cost for Employee/Family: $_____

Cost Frequency: _____

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Telephone: (670) 237-7602
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Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Pescription Drug Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $_____

Policy Group Name/Number: _____ Cost for Listed Children: $_____

Cost for Employee/Family: $_____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Mental Health Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $_____

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Facsimile: (670) 664-2349

Policy Group Name/Number: _____ Cost for Listed Children: $_____

Cost for Employee/Family: $_____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Other Health Insurance (specify type here):

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $_____

Policy Group Name/Number: _____ Cost for Listed Children: $_____

Cost for Employee/Family: $_____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

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Telephone: (670) 237-7602
Facsimile: (670) 664-2349

Certification Information

Completed by:

Name and Title: _____

Company Name: _____

Signature:_____

Date:_____ Phone Number:_____

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