Proof of Insurance Form

F E B C O

Benefits Consultants

Form: PROOFINSURANCE05232013

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.***

Signature

Employee Signature: _____ Date: _____

Please fax this form to: 502-695-9692

www.febco.com

Febco Inc.
PO Box 5010
Frankfort KY 40602
1-800-489-1539