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HEALTH INSURANCE PREMIUM VERIFICATION

TO: _____

_____

_____

TEL.#: _____

FROM: _____

_____

TEL.#: _____

DATE: _____ **APT. #:** _____

DEVELOPMENT NAME: _____

RE: _____

CONTACT PERSON: _____

FAX #: _____

In order to comply with federal regulations requesting verification on all income, assets and allowances for residents of tax credit housing, please complete the following information and return it as soon as possible to the above address.

All medical expenses, which are described below may be listed as allowances to help reduce my rental cost.

I hereby authorize release of any information requested regarding my income, assets, and allowances.

_____ _____

Applicant/Resident Signature | Social Security Number

TYPE OF POLICY	POLICY NUMBER	ANNUAL PREMIUM	DEDUCTIBLE	% PAID AFTER DEDUCTIBLE MET
1.				
2.				
3.				

Does the policy have prescription coverage? ☐ YES ☐ NO

If yes, what is the deductible for prescriptions? $_____

_____ _____

Signature of Person Verifying Information | Telephone Number

_____ _____

Title | Date

OFFICE USE ONLY:

EQUAL HOUSING OPPORTUNITY

We encourage and support the nation's affirmative housing program in which there are no barriers to obtaining housing because of race, color, religion, sex, national origin, handicap or familial status.

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