GOVERNMENT OF THE VIRGIN ISLANDS
GROUP HEALTH INSURANCE
PERSONNEL OFFICE
GERS COMPLEX 48 B-50C KROPRINOSEN GADE
ST. THOMAS, VIRGIN ISLANDS 00802
774-8588

HEALTH INSURANCE REPORTING FORM

Name of employee _____ Male ☐ Female ☐

Date of birth _____ Employee Number _____

Social Security Number _____

EMPLOYMENT STATUS

I. NEW EMPLOYEE Permanent ☐ Temporary ☐ Date Hired: _____ Payroll account code: _____

PLEASE HAVE THE EMPLOYEE COMPLETE AND SIGN THE HEALTH INSURANCE ENROLLMENT FORM:
If this employee was previously employed by the V.I. Government please indicate the last:

Department _____

Agency _____

Period of employment _____

IF THIS EMPLOYEE IS A TRANSFERRED EMPLOYEE PLEASE DO NOT COMPLETE THE ABOVE SECTION, BUT COMPLETE THE FOLLOWING:

II. TRANSFERRED From: To:

Department Division or Agency	Department Number	Department Division or Agency	Department Number

III. PLEASE COMPLETE IF THE FOLLOWING APPLIES TO ANY EMPLOYEE:

Resigned ☐ Date _____

Deceased ☐ Date _____

Dismissed ☐ Date _____

Terminated ☐ Date _____ Reason _____

IV. PLEASE COMPLETE IF THE FOLLOWING APPLIES TO ANY EMPLOYEE WHO IS ON (Attach letter with department approval for leave) LEAVE WITHOUT PAY:
From: _____ To: _____

V. PLEASE COMPLETE IF THE FOLLOWING APPLIES TO ANY EMPLOYEE:

(Attach copy of NOPA) OFFICIAL NAME CHANGE:

From: _____ To: _____

_____
SIGNATURE
(NAME AND TITLE)

_____
DEPARTMENT, DIVISION, AGENCY

_____
DATE AND PHONE NUMBER