

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 _____

EMPLOYMENT STATUS

Social Security Number _____

I. NEW EMPLOYEE Permanent ☐ Date Hired: _____
Temporary ☐ 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