

STATEMENT BY EMPLOYEE

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip Code: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Alternate Telephone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# (Optional): \_\_\_\_\_

Subscriber ID # \_\_\_\_\_

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1. When did you begin employment with Pace Airlines?
2. What insurance company was your group health/life insurance coverage with?
3. When did you begin your group health/life insurance coverage?
4. What date was your group health/life insurance cancelled?
5. Were you given 45 days written notice that your group health/life insurance was being cancelled?

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_