

PLAN ELIGIBILITY / WORK STATUS FORM

Employer _____

Employee _____ Social Security # _____ D.O.B _____

Dependent _____ Social Security # _____ D.O.B _____

Claimant Relationship to Employee _____

Employee's date of hire _____ Employee's Effective Date _____ Dependent Effective Date _____

Employee's last date of work _____ Expected Date of Return to work _____

Employee's Current Employment Status

Actively at Work _____ hours per week as of (date) _____

Retired as of (date) _____ Reason for retirement _____

Currently Disabled Condition _____

Dates of disability: from _____ to _____ Anticipated date of return to work _____

Has the employee/dependent qualified for Medicare due to age, disability or end stage renal disease? Y _____ N _____

If yes, please list reason(s) _____ Medicare Effective Date _____

Leave of absence for medical or personal reasons (Please give duration and details) _____

Temporarily laid off (please give duration and details) _____

Is the claimant a COBRA participant? If yes, please list the Qualifying Event _____

COBRA Effective Date _____ Premium Paid Thru Date _____ Termination Date _____

Dependent covered under any other group insurance plan. Please provide details _____

Is Dependent over age 19? Yes No

If yes, please provide name and address of school attending _____

*If applicable, please forward a copy of the HIPAA Credible Coverage documentation.

*Please attach a copy of supporting documentation for any question answered in the affirmative above.

Additional Comments _____

Name/Title of Employer's Authorized Representative

Signature

Date