Work / Eligibility Status Form

Date: _____

RE: Employee: _____ Claimant: _____

Employer: _____

Employee Social Security # or Alternate ID #: XXX-XX-XXXX_____

In order to update our reinsurance information files and to expedite the reimbursement process, please complete the form below and fax it to: _____or you may email it to: _____

1. Has the employee been out of work for any reason during the period of _____ through _____?

If yes, please complete the following; if no, please go to question 2:

Please indicate the date the employee was last at work: _____

Employee was on vacation/sick leave from: _____through _____
(Please forward a copy of your company policy for vacation/sick leave)

Employee was on a leave of absence from: _____through _____
(Please send a copy of Directors resolution or other formal company action approving the LOA)

Employee was out on disability extension from: _____through_____
(Please send a copy of the Board of Directors resolution or other formal company action approving the disability leave)

Employee's employment was terminated on: _____

Employee elected COBRA coverage effective: _____
(Please forward a copy of the Notice of Rights form that was sent to the employee: if you do not administer COBRA, please also forward a copy of the COBRA election form and record of COBRA premium payments)

2. During the same period as above, has the employee continued to work but worked less than the "Actively-at-Work" hours but continued to be covered under your health plan due to vacation or personal/sick time off?

_____

_____

Please sign: _____ Title:_____ Date:_____

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