

Employee Eligibility Information

Administrator: _____

Group Name: _____

Employee ID #: _____

Employee: Last _____

First _____

Date of Hire: _____

Coverage Effective Date: _____

Still actively employed: Yes ___ No ___

If yes, hours worked/week: _____

Has the employee missed any work due to illness/injury within a 12 month period?

Yes ___ No ___

If yes, what the last day the employee was actively at work prior to absence?

Date employee returned to work.

How does the employer calculate the 12 month period?

Calendar year _____

If other than calendar year, (fiscal, first date of FMLA, etc)

Other _____

For time missed, # of sick days used: _____

Indicate the dates sick time used: _____

For time missed, # of vacation days used: _____

Indicate the dates sick time uses: _____

How is employee's coverage being continued under the plan during their illness/injury?

Employee actively at work _____

Employee Retired ___ Date _____

** If FMLA, LOA, or Cobra, all supporting documentation including employee handbook detailing FMLA/LOA options or Cobra proof of premium payments must be submitted**

Premiums paid by: Employer ___ Employee ___

Premiums paid through _____

Family Medical Leave Act: Yes ___ No ___

If yes, FMLA effective date: _____ FMLA ended: _____

Premiums paid by: Employer ___ Employee ___ Paid Through _____

Hours scheduled to work: _____ (1250 required for FMLA) Does FMLA run concurrently with LOA? Yes ___ No ___

Medical/Disability Leave of Absence (LOA)

Effective: _____ Return to work: _____

Premiums paid by: Employer ___ Employee ___

Premiums paid through: _____

Cobra: Effective: _____ Ended: ___ Qualifying event: _____ Date of Event: _____

Premiums Paid through: _____

Is employee eligible for Medicare? Yes ___ No ___

Signature: _____ Print Name: _____

Date: _____

Title: _____