Eligibility Verification Form

Employee			
Claimant			
Eligibility			
Employee's date of birth	Date of hire	Original Effective date	
Employee zip code	Plan Elected		
Claimant's original effective date		Claimant's date of birth	
Please provide timely enrollment documentation for all newborn Claimants			
Work Status Information			
In the past 12 months, has the Employee missed time from work?		◯ Yes	◯ No
If Yes, please complete the following:			
Last day worked	Return to work date		
Sick Leave Used	From	Through	
Vacation Time Used	From	Through	
Family Medical Leave Act (FMLA)	From	Through	
Leave of Absence	From	Through	
Short Term Disability	From	Through	
Is FMLA: ◯ Rolling 12 month or ◯ Calendar year ◯ Intermittent - Please attach a list of days and hours used.			
IMPORTANT NOTE: If not stated in the Plan Document, please submit a complete copy of the Employee Benefit Handbook or Leave Policy detailing how the employee maintained their medical benefits while out on leave.			
COBRA Information			
NOTE: Please include a copy of the COBRA election form and documentation of COBRA premium paid for all months, if applicable.			
Date of Termination	If coverage has terminated, has COBRA been elected?	◯ Yes	◯ No
General Comments			

Print name _____ Title _____

Authorized Signature _____ Date _____

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