



EMPLOYEE ELIGIBILITY VERIFICATION FOR STOP LOSS CLAIMS FORM

Employer / Group: _____ Plan Year: _____

Employee Name: _____

Date of Hire: _____

Original Effective Date of Coverage: _____

1. What is the employment status of this person? Please check all that apply:

☐ Actively Working

☐ Terminated Termination Date: _____

☐ Retired Retirement Date: _____

☐ Medical Leave of Absence from: _____ to: _____

☐ FMLA from: _____ to: _____

☐ Other Leave Describe type of leave used: _____
From: _____ to: _____

2. Please provide the employee's last day worked and return to work date for all absences during the above referenced plan year. Please indicate (in the Time Used column below) how coverage for medical benefits was continued during the absences:

S (sick time); **V** (vacation time); **P** (paid leave); **U** (unpaid leave w/employee contributions continued)

a. Last Day Worked: _____ Returned to work: _____ Time Used: _____

b. Last Day Worked: _____ Returned to work: _____ Time Used: _____

c. Last Day Worked: _____ Returned to work: _____ Time Used: _____

3. If the employee has not returned to work, what is the expected return to work date?

4. If coverage terminated, has COBRA been elected?

☐ No ☐ Yes Effective Date: _____ (provide copy of COBRA election form and proof of COBRA premium payments through current month)

Length of COBRA coverage: ☐ 18 months ☐ 29 months ☐ 36 months

5. Is the employee covered under Medicare? ☐ No ☐ Yes (If yes, provide Medicare effective date)

6. How did the employee qualify for Medicare? ☐ Age ☐ Disability ☐ ESRD

Completed By: _____

Company Name: _____

Title: _____ Date: _____