



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 copy of Medicare card)

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

Completed By: \_\_\_\_\_

Company Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_