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| **CONFIRMATION OF ELIGIBILITY FORM** |
| Date: |
| **Policyholder**:  **Policy Period:**  **Carrier:**  **Employee**:  **Claimant**: |
| **Form instructions and notes:**  Please return the completed form and any additional information to the Tokio Marine HCC – Stop Loss Group address listed above. |
| **SECTION 1 - Eligibility** |
| **NOTE:** You may complete this section or provide system screen prints that include date of hire, original effective date for both the Employee and the Claimant, type of coverage (single/family), covered dependents and changes to coverage.  Employee’s date of hire:  Effective date:  Date of birth:  Original medical effective date with Employer:  Employee zip code:  Employee type of coverage:  Claimant’s original medical effective date:  Claimant’s date of birth:  \*\*\*Please provide documentation of timely enrollment on all newborn Claimants.\*\*\* |
| **SECTION 2 - Work Status** |
| In the past 12 months, has the Employee missed time from work?  Yes  No  If yes, please complete the type of leave used by the Employee:   1. Sick time (PTO):  to 2. Vacation time (PTO):  to 3. Family Medical Leave Act (FMLA):  to   Rolling 12 month or  Calendar year  Intermittent - Please attach a list of days and hours used. 4. Short Term Disability (STD):  to 5. Long Term Disability (LTD):  to   LTD premiums paid through:  (Please include a copy of the complete premium verification.)   1. Other Leave of Absence (LOA):  to 2. Layoff or furlough:  to .   Is Lay off or Furlough related to COVID-19?  Yes  No  How are medical premiums being paid for employee during the layoff or furlough period?  Employer Paid  Employee Paid |
| **SECTION 2 - Work Status (Continued)** |
| Medical premiums paid from  to .  If employee paid premiums, please include a copy of the complete premium verification.  **IMPORTANT NOTE:** If not stated in the Plan Document, please submit a complete copy of the Policyholder’s benefit handbook detailing the benefits: **Short Term Disability**, **Long Term Disability** and **Other Leave of Absence** (Items D, E and F above). |
| Please provide additional information regarding the Employee’s leave:   1. What was the last date Employee was actively working prior to leave? 2. Please include dates of previously used FMLA or LOA taken during the past twelve (12) months. 3. Is the Employee currently active at work?  Yes  No   If yes, please enter number of hours worked each week:  If no, please provide last date of full-time work:   1. When did the Employee return to work full time? 2. What is the anticipated return to work date? 3. Has the Employee retired?  Yes, date retired:   No   Retiree premiums have been paid from  to  by  Employee  Retiree  If premiums are retiree paid, please provide proof of retiree paid premiums to date during the policy year. |
| **SECTION 3 - COBRA** |
| **NOTE:** Please include a copy of the COBRA election form and verification of the COBRA premium paid for all months, if applicable.   1. Submit verification of COBRA premium paid for this additional period: . 2. If coverage has terminated, has COBRA been elected?  Yes  No 3. Medical coverage termination date prior to COBRA election: 4. COBRA effective date: 5. Length of eligible COBRA coverage:  18 months  29 months  36 months |
| **SECTION 4 - Other Coverage / Coordination of Benefits** |
| **NOTE:** Information must be within 12 months of the claim incurred date. You may complete this section or provide a system screen print of the information or signed documentation from the Employee. All documentation must include the date coverage was last verified.  Do any of the Employee’s **Dependents** have any other group health insurance coverage?  Yes  No   1. Date “Other Coverage” was last verified with the Employee: 2. Name of other insurance carrier: 3. Name of the employer: 4. Name of the insured: 5. Date of birth: 6. Effective date of coverage: 7. Relationship to Claimant: |
| **SECTION 4 - Other Coverage / Coordination of Benefits (Continued)** |
| Is the **Employee** covered under Medicare?  Yes  No   1. Part A  Yes  No Effective date: 2. Part B  Yes  No Effective date: 3. What is qualifying event?  Disability  ESRD  Age   Is the **Claimant** covered under Medicare?  Yes  No   1. Part A  Yes  No Effective date: 2. Part B  Yes  No Effective date:   Claimant’s Medicare Identification Number (From Medicare ID card):  What is the Claimant’s Medicare qualifying event? Disability  ESRD  Age |
| **SECTION 5 – General Comments** |
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Print Name Title

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Authorized Policyholder’s Signature Date