EMPLOYEE / CLAIMANT **ELIGIBILITY FORM**

DRM DALLAS RISK MANAGEMENT

POLICYHOLDER NAME

POLICY EFFECTIVE DATE

EMPLOYEE NAME

EMPLOYEE DOB

HIRE DATE

ORIGINAL EFFECTIVE DATE

NUMBER OF HOURS EE WORKS PER WEEK

TERMINATION DATE IF APPLICABLE

RETIREMENT DATE IF APPLICABLE

CLAIMANT NAME

CLAIMANT DOB

CLAIMANT EFFECTIVE DATE

RELATIONSHIP TO EE

TERMINATION DATE IF APPLICABLE

IS EMPLOYEE ACTIVELY AT WORK? ◯ YES ◯ NO

TIME ABSENT FROM WORK (SPECIFIC DATES FOR ALL ABSENCES):

FROM		TO	
FROM		TO	
FROM		TO	
FROM		TO	
FROM		TO	
FROM		TO	

HOW COVERAGE WAS MAINTAINED: FMLA, SICK TIME, PTO, VACATION, STD, LTD, OTHER

EXPECTED RETURN TO WORK DATE IF EMPLOYEE HAS NOT RETURNED:

DOES CLAIMANT HAVE OTHER INSURANCE? ◯ YES ◯ NO

IF YES, PLEASE PROVIDE OTHER COVERAGE INFORMATION (INSURANCE CARD, SUBSCRIBER, EFFECTIVE DATE)

DOES CLAIMANT HAVE OTHER INSURANCE?

OTHER COVERAGE TERMINATED? ◯ YES ◯ NO

TERMINATION DATE:

IS CLAIMANT COVERED UNDER MEDICARE? ◯ YES ◯ NO

IF YES, WHAT IS THE MEDICARE QUALIFYING EVENT?

IF ESRD, PROVIDE 1ST DATE OF DIALYSIS

HAS COBRA BEEN ELECTED: ◯ YES ◯ NO

IF YES, PLEASE PROVIDE OTHER COVERAGE INFORMATION (INSURANCE CARD, SUBSCRIBER, EFFECTIVE DATE)

COBRA EFFECTIVE DATE

COBRA TERMINATION DATE IF APPLICABLE

COBRA PAID THROUGH

PLEASE PROVIDE COBRA ELECTION FORM AND PROOF OF PREMIUM PAYMENTS MADE TO DATE.

SIGNATURE

COMPLETED BY

TITLE

DATE