Select Health

Confirmation of Eligibility / Work Status / Coordination of Benefits (COB) Form

Please email the completed form to: StopLossCoordinators@selecthealth.org. Please attach any additional documentation (case management reports, utilization review reports, and other applicable documentation) in the same email as this form.

Policyholder (First and Last Name): *

Subscriber ID #: *

Contract Period:

Carrier:

Claimant:

Employee's date of hire:

Effective Date:

Date of birth:

Spouse/Dependent's Effective Date:

Spouse/Dependent's Date of birth:

In the past 12 months has the employee remained active? ☐ yes ☐ no

If No, please indicate the type of leave and inactive dates:

Sick Time (PTO) Start/End Date: to

Vacation Time (PTO) Start/End Date: to

Family Medical Leave Act (FMLA) Start/End Date: to

Short Term Disability: ☐ yes ☐ no

Long Term Disability: ☐ yes ☐ no

Other Leave of Absence:

IMPORTANT NOTE: *If not stated in the Plan Document, submit a complete copy of the Employer's benefit handbook showing the benefits: Short Term Disability, Long Term Disability and Other Leave of Absence.*

Is the Employee currently active at work? ☐ yes ☐ no

If yes, please list the number of hours worked each week:

If no, please indicate the last date of full-time work:

When did the Employee return to work full-time?

When is the anticipated return to work date?

If coverage has terminated, has COBRA been elected? ☐ **yes** ☐ **no**

COBRA Effective Date:

(Include copy of COBRA Election Form & complete premium verification.)

Length of eligible COBRA coverage:

Is the Employee covered under Medicare? ☐ **yes** ☐ **no**

Is the Claimant covered under Medicare? ☐ **yes** ☐ **no**

What is the Medicare qualifying event?

Has the Employee retired? ☐ **yes** ☐ **no**

If Yes, date retired:

Do any of the dependents have any other group health insurance coverage? ☐ **yes** ☐ **no**

Date "Other Coverage" was verified with the employee:

Name of other insurance carrier:

Name of other insurance policyholder:

Date of birth of other insurance policyholder:

Comments:

Once the required information is received, we will continue to review your reimbursement request. If you have any questions or need additional assistance, please email StopLossCoordinators@selecthealth.org.

Signature (type here) **Date**