INSURANCE DESIGN ADMINISTRATORS

ELIGIBILITY STATUS FORM

Periodically, a review of eligibility is required in order to confirm the accuracy of the information in our files. In order to confirm and/or update our files, the following information is required. Please answer all questions in Sections I - IV of this form. This information will be verified as accurate by the signature(s) of the employee and employer at the bottom of this form.

THIS INFORMATION IS REQUIRED.

Employer/Client/Group Name _____

SECTION I – Employee

Employee name: _____
Last, First, MI

Street address: _____ City, State, Zip: _____

Employee phone number: _____ Employee birth date: _____ Employee SSN/ID#_____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Legally separated ☐ Widow/Widower

Date of hire: _____ Effective date of coverage _____

Medical coverage: ☐ Single ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family ☐ No Medical coverage ☐ Coverage thru another carrier _____

Dental coverage: ☐ Single ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family ☐ No Medical coverage ☐ Coverage thru another carrier _____

SECTION II – Spouse

1. Name of Spouse? _____
2. Is your Spouse Employed? ☐ Yes ☐ No Name of Employer _____
3. Does your Spouse have other coverage? ☐ No
   ☐ Yes, coverage is provided through: _____ If Medicare: ☐ Part A - Effective date:_____
   Insurance Carrier
   Coverage: ☐ Single ☐ Employee/Spouse ☐ Employee/Child ☐ Family ☐ Part B - Effective date:_____
   ☐ Medical ☐ Dental ☐ Rx ☐ Vision
   ☐ No, no other coverage
4. If family coverage is through your Spouse's employer, specify which child(ren) is(are) covered under his/her plan and what type of coverage exists.

_____

_____

SECTION III – Retiree

1. Do you or anyone have Retiree coverage from a previous employer? ☐ Yes ☐ No Coverage through: ☐ Former Employer ☐ Spouse
2. The retirement date: _____
3. Is the employee covered by Medicare? ☐ Yes ☐ No Effective date: _____ Due to: ☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD)
4. Is the employee receiving SSI Benefits? ☐ Yes ☐ No Effective date: _____ Due to disability? ☐ Yes ☐ No
5. Is the Spouse/dependent covered by Medicare? ☐ Yes ☐ No Effective date: ___ Due to: ☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD)
6. Is the Spouse/dependent covered by any other group health plan, including Medicare during the contract year? ☐ Yes ☐ No If "yes", please provide the following: Name:_____ Relationship: ☐ Spouse ☐ Dependent If Medicare: ☐ Part A - Effective date:_____
   Carrier: _____ Effective date: _____ Termination date: _____ ☐ Part B - Effective date:_____

SECTION IV – Dependent Child(ren)

Full-time Student *(if applicable)* **(College or Higher Education) Information**, *(Applies only to a specific coverage provided by the Employee)*

1. Name of dependent/student enrolled? _____
2. What school does the student attend? _____
3. What is the expected date of graduation? _____

Forward this form along with PROOF OF ENROLLMENT and your claim will receive immediate attention. For additional students please attach a separate page.

Other Dependent Child(ren) Information

1. Is this dependent employed at the present time? ☐ Yes ☐ No If so, ☐ full-time or ☐ part-time employee?
   Number of hours per week? _____ Does his/her employer provide coverage? ☐ Yes ☐ No
   If so, Employer's name and address: _____
   Does dependent have coverage with another insurance plan through the other parent? ☐ Yes ☐ No
   If so, Insurance Company's name: _____
2. The plan requires dependency on the covered employee. Please provide answers to the questions below indicating that the dependent meets the definition of a dependent under the terms of this plan.
   Primary residence address of covered employee: _____
   Primary residence address of dependent: _____
   Confirm dependent resides with covered employee: ☐ Yes ☐ No Marital status of dependent: ☐ married ☐ unmarried
   Dependent is declared by covered employee, in accordance with eligibility requirements set forth by the IRS? ☐ Yes ☐ No
   Proof may be required upon request.
3. Please advise whether this dependent is covered under another Health Plan, the coverage and with and through whom this coverage is provided.
   ☐ Yes, coverage is provided through: _____
   Name of Insured Insurance Co.
   Coverage: ☐ Medical ☐ Dental ☐ Rx ☐ Vision
   ☐ No, no other coverage

Your assistance with obtaining this information for our file is appreciated. If you should have any questions regarding this request, please contact your benefits office.

By signing this Enrollment Status Form, I declare all the information above is true and complete to the best of my knowledge. I understand, failure to return this form in a timely manner with accurate and complete information may result in claim delays or denial of benefits. Further, I understand, if any information contained on this Form is inaccurate, coverage may be rescinded or modified, benefits may be denied, any benefits paid in error may be recovered (for which I could be personally responsible), in addition to being subject to legal action.

Name and title of group representative who verified the eligibility information stated above:

_____

Name of Authorized Employer Title Date Employee/Participant Signature Date