

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.

SECTION I - Employee

Employer/Client/Group Name

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:

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: