

UHY ADVISORS - INSURANCE DESIGN ADMINISTRATORS

ELIGIBILITY STATUS FORM

Periodically a review of the eligibility is required in order that we can confirm the accuracy of the information on our files. In order to confirm and/or update our files the following information is required. Please answer any and all questions in sections on this form. This information will be verified by the employee and employer as accurate by the signature(s) below. 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 () Other Coverage thru another carrier _____

Dental coverage: () Single () Employee/Spouse () Employee/Child(ren) () Family () No Medical coverage () Other 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: _____
Insurance Co.

Coverage: () Single () Employee/Spouse () Employee/Child () Family
() Medical () Dental () Rx () Vision

() No, no other coverage

4. If family coverage is through your spouse's employer, specify which child(ren) is 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 covered by Medicare? () Yes () No Effective date: _____ Due to: () Age () Disability () End Stage Renal Disease (ESRD)

6. Is the spouse covered by any other group health plan during the contract year? () Yes () No If "yes", please provide the following:

Carrier: _____ Effective date: _____ Termination date: _____

SECTION IV – Full-time Student (College or Higher Education)

1. Name of dependent/student enrolled? _____

2. What school does the student attend? _____

3. What is the expected date of graduation? _____

Please forward this form along with PROOF OF ENROLLMENT FROM THE ABOVE-MENTIONED SCHOOL to us and your claim will receive our immediate attention. For additional students please attach a separate page.

SECTION V – Dependent Child(ren)

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, name and address: _____

Does dependent have coverage with another insurance plan through the other parent? () Yes () No

If so, who?: _____

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 above information 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