SKYWARD SPECIALTY INSURANCE | Accident & Health

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ELIGIBILITY VERIFICATION

This form is being completed for the time period to
(This form is to be completed by the Employer)

Part I

Employee Name:	ID#:
Date of Birth:	Date of Hire:
Original Insurance Effective Date:	Medicare Effective Date (if applicable):
Is Employee currently working fulltime and performing the duties of their job?:	

Part II

Please provide the last day the Employee was actively-at-work on a regular basis as defined by the Plan.
Return to work date:

Part III

Has employment been terminated? Yes ☐ No ☐
Is COBRA applicable? Yes ☐ No ☐ If Yes, what is the COBRA effective date: Premiums paid through: Please attach the election form and supporting documentation of paid premiums. Verification of other insurance may be needed for COBRA recipients.

Part IV **(Please indicate any dates the Employee was absent during this period. Specify the dates of each absence, how eligibility was maintained, and certify who paid the medical plan premium while on unpaid leave.)**

	From:	To:	Total Time Used:	Premiums Paid By EE or ER:
Sick Leave Used:				
Vacation Time Used:				
FMLA*:				
Other (please explain if checked):				

***Additional documentation (such as copies of checks, payroll records, or ledgers) may be required to substantiate that the Employee's medical premium is being paid while on FMLA or other unpaid leave**
(Employee must be employed for at least 12 months and has completed at least 1,250 hours of service to be eligible for FMLA)

On what basis is FMLA measured; 1) Calendar year, 2) Date Employee's leave begins or, 3) Rolling 12 months from the date the Employee uses leave?

If the leave of absence was intermittent, please provide all start and end dates. Documentation, i.e., time sheets, payroll records may be requested.

Start date:	End date:
Start date:	End date:
Start date:	End date:

Part V

If the Employee had no absences during the period reference above, please check here: ☐

Part VI

I CONFIRM THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS ACCURATE AND CURRENT.

Authorized Signature:	Title:
Group Name:	Date: