

Health Continuation of Coverage Questionnaire



Employer Name: _____

Employee Name: _____

Date of Hire: _____ Employee is: Hourly Salary Full-Time Part-Time

Original Effective Date: _____ Termination Date: _____

Is the Employee still actively working? Yes No Retired

Please advise the number of hours the employee typically works each week: _____

Please provide the following information for all absences the employee had during the last 12 months:

1. Has the employee missed any work during the last 12 months: Yes No

If yes: A. Last date employee was actively at work: _____

B. Date employee returned to work: _____

C. Did employee return to work full-time or part-time: _____

2. Please indicate (use exact dates) how coverage has been continued while out of work?

Sick Time: _____

Vacation Time: _____

Family Medical Leave Act (FMLA): _____

(Please attach all FMLA documentation, including proof of premium payments)

Approved Medical Leave (other than FMLA): _____

(Please attach all medical leave documentation, including proof of premium payments)

Other Absence (Explain): _____ Dates: _____

3. Were premiums paid during FMLA/LOA: Yes No If paid, by whom: _____

4. If coverage was terminated, has COBRA been elected? Yes No

Effective Date of COBRA: _____ COBRA Termination Date: _____

Qualifying Event: _____

Date of Qualifying Event: _____ Date Premiums Paid Through: _____

(Please attach COBRA documentation, including signed and dated COBRA election form and proof of premium payments)

ADDITIONAL COMMENTS:

This form must be fully completed and signed by the employer representative.

Signature: _____ Title: _____

Printed Name: _____ Date: _____

Please email this form to slclaims@starlinegroup.com.

V2021