Health Continuation of Coverage Questionnaire

STARLINE

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 claimant was actively at work: _____

   B. Date claimant returned to work: _____

   C. Did claimant 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.