PARTNERS
MANAGING GENERAL UNDERWRITERS

Please complete and return to one of the following:

Email: claims@partnersmgu.com
Fax: 480.750.1395

Eligibility Form

Policyholder Name

Employee Name | Employee Date of Hire

# of Hours Employee works per week | Employee's date of Retirement, if applicable

Claimant Name | Relation to Employee

Original effective date of coverage (Employee and Claimant)

Work Status: Is the Employee actively at work? ☐Yes ☐No

Please advise the employee's last day worked and the date returned to work for all absences during the policy period:

a. Last day worked _____ Returned to work _____
b. Last day worked _____ Returned to work _____
c. Last day worked _____ Returned to work _____

How did the employee continue to be eligible under the medical plan while not actively at work?

Please use **specific dates:**

a. Sick Time _____ to _____
b. Vacation _____ to _____
c. FMLA _____ to _____
   i. FMLA calculation method: ☐ Calendar Year ☐ Rolling 12 Months ☐ Intermittent
   ii. Start Date if Rolling 12 Months or Intermittent: _____
   iii. Sick/Vacation time concurrent with FMLA? ☐ Yes ☐ No
d. STD/LTD _____ to _____
e. Other _____ to _____
   If Other, please explain: _____
f. Were all medical premiums paid while the employee was not working? ☐Yes ☐No
   If **No**, please explain: _____
   If the Employee has not returned to work, do you have an expected return date for them? _____

OTHER INSURANCE: Does the claimant have other medical insurance? ☐Yes ☐No

If **Yes**, provide supporting documentation of other insurance (copy of Other Insurance card, subscriber).

COBRA: Has COBRA been elected? ☐Yes ☐No COBRA Effective Date: _____

If Coverage has terminated, please provide termination date: _____

Has COBRA premium been paid to date: ☐Yes ☐No

If **Yes**, provide a copy of the signed and dated COBRA election form and proof of premium payments made to date.

MEDICARE: Is claimant covered under Medicare? ☐Yes ☐No If **Yes**, what is the Medicare qualifying event?

☐ Age ☐ Disability ☐ ESRD If **ESRD**, please provide first date of dialysis: _____

Form Completed By

Signature | Title | Date