iiSi A DIVISION OF COMPANION LIFE INSURANCE COMPANY

Excess Loss Work Status Form

Contractholder Information

Contractholder: _____ Contract Period: _____

Employee Information

Employee Name: _____ Original Effective Date: _____

Date of Birth: _____ Date of Hire: _____

Termination Date: _____ Plan Termination Date: _____ Retirement Date: _____

COBRA Effective Date*: _____ COBRA Paid to Date: _____ COBRA Termination Date: _____

*COBRA election form and proof of COBRA premium payments must be provided.

Employment Status Information

Has the employee remained actively at work during the entire contract period? ☐ Yes ☐ No

If yes, provide number of hours worked per week? _____ Date employee began working these hours: _____

If no, provide last date worked: _____ Date employee returned to work: _____

If the employee has not returned to work, please provide the expected return date: _____

Has the employee qualified for Medicare? ☐ Yes* ☐ No *Effective Dates: | Part A: _____ Part B: _____

Qualifying Event: ☐ Age ☐ Disability ☐ ESRD (Please provide first date of dialysis: _____)

Time off Work

Provide all dates of leave used by the employee to remain eligible for coverage under the medical plan while not actively at work. NOTE: For FMLA, STD/LTD, and Leave of Absence, proof of employee's premium payment must be provided.

Leave Type:	List all Dates:
☐ Sick/Vacation/PTO:	_____
☐ FMLA:	_____
☐ STD/LTD:	_____
☐ Leave of Absence:	_____
☐ Other:	_____

Explanation: _____

_____

Form completed by: _____ Title: _____

Date: _____

Please submit completed forms to: **claims@iisinet.com**

FRAUD NOTICE: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.