Work Status Questionnaire

Please submit this form to:
medTRANS Insurance
Frontrunner Captive Management, inc.
303 West Main St. Suite 300
Freehold, NJ 07728
Phone: 732.414.2942
rbeckie@frontrunnercaptive.com

This information is needed in order to verify that the claimant's benefit continuation during the absence from work was in accordance with the continuation of coverage requirements outlined in the Summary Plan Description (SPD). Please review the information below and provide the necessary documentation.

Date: ____________________

RE: Claimant: ____________________________________ ☐ **Employee** ☐ **Dependant**

Employer Name ______________________________

Stop Loss Group Number ______________________

Stop Loss Effective Date ______________________

1. Has the employee missed any work due to illness/injury within the last 12 months? ☐ YES ☐ NO

If yes, please provide the actual dates for the following:

a. **When was the last day the employee was actively at work?** ____________________

b. **What was the date the employee returned to work?** ____________________

c. **What is the employee's Hire Date?** ____________________

d. **What is the employee's Original Effective Date of Coverage?** ____________________

2. Sick Days: For the time missed from work, what were the number of sick days used and what where the dates of the sick time?

a. **Total # sick days used** ____________

b. **Dates of sick time:**

i From ____________________ To: ____________________

ii From ____________________ To: ____________________

iii From ____________________ To: ____________________

3. Vacation Days: For the time missed from work, what were the number of vacation days used and what were the dates

a. **Total # vacation days used** ____________________

b. **Dates of vacation time:**

i From ____________________ To: ____________________

ii From ____________________ To: ____________________

iii From ____________________ To: ____________________

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4. How is the employee's coverage being continued under the plan during his/her illness or injury?

a. **Employee is Actively at Work** ☐ YES ☐ NO

b. **Employee is Retired** ____________________

i Premiums are paid by: ☐ Employee ☐ Employer ☐ Both

c. **Family Medical Leave Act (FMLA)**

i. Effective Date ____________________

ii. End Date ____________________

iii. Total Hours Scheduled to work ____________________

iv. Premiums are paid by: ☐ Employee ☐ Employer ☐ Both

d. **Medical/Disability Leave of Absence (LOA)**

i. Effective Date ____________________

ii. End Date ____________________

iii. Premiums are paid by: ☐ Employee ☐ Employer ☐ Both

e. **COBRA**

i. Effective Date ____________________

ii. End Date ____________________

iii. Qualifying Event ____________________

iii. Premiums are paid by: ☐ Employee ☐ Employer ☐ Both

Please supply supporting documentation if employee is on FMLA, Leave of Absence of COBRA, including

Employee Handbook which explains the FMLA or LOA

Proof of Premium Payments during leave

COBRA Election Form

Proof of COBRA Premium Payments

Banked Hours - Please provide a copy of Banked Hours and/or verification of self-pay premiums

____________________ Signature & Date

____________________ Authorized Signatory

____________________ Phone

____________________ E-mail