USBenefits
Insurance Services, LLC

Work Status Form

Group Name: _____ Member: _____

Patient: _____ DOB: _____

Plan Year: _____

_____ has exceed the specific deductible for this plan year, and we are in need of the following information.

1. Has the employee been absent from work at anytime during the policy year? ☐ Yes ☐ No

2. Last day actively at work: _____

3. How was eligibility and coverage maintained? _____

Vacation time:	From: _____	To: _____
Sick Time:	From: _____	To: _____
STD:	From: _____	To: _____
LOA	From: _____	To: _____
COBRA:	From: _____	To: _____
FMLA:	From: _____	To: _____
Other:	From: _____	To: _____

Clear Form

For STD, LOA, COBRA and Other, please send copies of disability letter, LOA letter, COBRA election form, and for other letter of explanation and a copy of the policy from the employee handbook. For COBRA and any other event that was not covered by employment copies of premium payments will be required.

Date employee expected to return to work:_____ Date employee returned to full time work:_____

Authorized Employer Signature:_____ Date Signed:_____

877.877.4USB (4872)
USBenefits Insurance Services, LLC
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