bardon insurance group, inc.

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Actively-at-Work Status Questionnaire

This form must be completed and returned to continue the audit process on the specific claimant named below. For the purposes of stop loss reimbursement, Bardon will use this information to verify all eligibility requirements provided in the approved Plan Document have been followed.

Section A	*Group Name*		*Group ID*
	Enrollee Name		*Enrollee ID*
	Enrollee Hire Date		*Enrollee Effective Date*
Section B	*Patient Name*		
	Patient DOB	*Patient Effective Date*	*Relationship to Enrollee*

Section C	*Please provide the following information for the time period from:*	
	C1	*Did the employee have any absences from active work? (More than 5 intermittent or consecutive work days.) This applies whether the absence(s) was paid or unpaid.* ____ No ____ Yes
	C2	*Provide the last date the employee worked FT on a regular basis before the absence noted above:*
	C3	*During any significant absence from active work, did the employee apply for Short or Long Term Disability Benefits?* ____ *No* ____ *Yes* ____ *Not applicable*
	How did the employee maintain eligibility for plan benefits during their absence from work? Please note that AAW status is based on the Plan Document eligibility requirements and not the employee's position or compensation received while absent. The Plan does not make a distinction between a work-related absence and one that is due to a non-work related absence or LOA. (*Provide a list of the dates of all absences or attach separate time sheet documentation as is applicable.)*	
	C3	*PTO Dates/Hours:*
	C4	*FMLA Dates/Hours:*
	C5	*Leave of Absence (if plan allows) Dates/Hours:*
	C6	*COBRA effective date:* — *If the Plan Administrator does not handle your COBRA administration, please provide a copy of the signed and dated election form along with copies of COBRA payments or a log of same.*
	C8	*Other (provide details)*
	Time sheets may be requested for long term absences, or you may attach them to this form at this time.	
Section D	D1	*Has Employee returned to work?* ___No ___Yes – Date:____/____/_____
	D2	*In what capacity did the Employee return to work? (Details are required; please use additional paper if necessary)* ___ Part-time Dates: ____ Full-time Dates:
	D3	*Has employment terminated?* ____No ____Yes – Date: ____/____/____

Section E	*Completed by (print name)*	*Title*	*Date completed*
	Fax number:	*Phone number:*	*Email Address:*

PLEASE RETURN THE COMPLETED FORM DIRECTLY TO YOUR PLAN ADMINISTRATOR.