Ullico
SOLUTIONS FOR THE UNION WORKPLACE

WORK STATUS QUESTIONNAIRE

Please submit this form to:
The Union Labor Life Insurance Company

8403 Colesville Road
Silver Spring, MD 20910
202.682.0900

The Ullico Family of Companies

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 or Dependent]

Employer /Fund Name	[Policyholder]
Stop Loss Group Number	[Policyholder Group Number]
Stop Loss Effective Date	[Policyholder Effective Date]

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.

1) Has the employee missed any work due to illness/injury within the last 12 months? Please check: ☐ Yes ☐ No

If yes, please provide the actual dates [MM/DD/YY] 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 were 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 as the number of vacation days used and what were the dates of the vacation time?

a. Total # vacation days used _____

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b. **Dates of vacation time**:

i. From _____/_____/_____ To: _____/_____/_____

ii. From _____/_____/_____ To: _____/_____/_____

iii. From _____/_____/_____ To: _____/_____/_____

4) How is the employee's coverage being continued under the Plan during his/her illness or injury? (Please select from one of the following:)

a. **Employee is Actively at Work** Yes_____ No_____

b. **Employee is Retired** [Indicate Date Retired:] _____/_____/_____

i. Premiums are paid by: (Please check only one)

□ Employee □ Employer □ Both

c. **Family Medical Leave Act (FMLA)** [Indicate]

i. Effective Date _____/_____/_____

ii. End Date _____/_____/_____

iii. Total Hours Scheduled to Work: _____ Hours

iv. *Premiums are paid by: (Please check only one)

□ Employee □ Employer □ Both

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

i. Effective Date _____/_____/_____

ii. End Date _____/_____/_____

iii. *Premiums are paid by: (Please check only one)

□ Employee □ Employer □ Both

e. **COBRA**

i. Effective Date _____/_____/_____

ii. End Date _____/_____/_____

iii. Qualifying Event _____

iv. How are Premiums paid? (Please check only one)

□ Monthly □ Quarterly □ Annually

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Please supply supporting documentation if employee is on FMLA, Leave of Absence (LOA) or COBRA, including any of the following that apply:

- □ Employee Handbook which explains the FMLA or LOA policy;
- □ Proof of Premium Payments during leave
- □ COBRA Election Form
- □ Proof of COBRA Premium Payments.
- □ Banked Hours – Please provide copy of Banked Hours and/or verification of self-pay premiums.

_____

Signature & Date

_____

Authorized Signatory (Company & Title)

_____

Telephone Number