



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

## WORK STATUS QUESTIONNAIRE

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