SPECIFIC CLAIMANT WORK STATUS FORM

UME
Underwriting Management Experts

Please have this form completed and signed by the group's authorized representative. This should be filled out completely.

Group Name:_____Policy Effective Date:_____

Employee Name:_____Hire Date:_____

Claimant Name:_____

Original Effective Date of Employee:_____

(Month/Day/Year)

In order to process the specific claim submitted to Underwriting Management Experts, we will need the following information:

1. Time taken off work by the employee for this accident or illness. Please be specific with dates.

_____

_____

2. Explain how the employee-maintained coverage under the plan for the dates listed above.

_____

_____

3. List the date the employee returned to work with a full-time status as defined by the plan document.

_____

_____

4. If the employee has not returned to work, specify how coverage is being maintained. Be sure to include any pertinent documentation to support leave (i.e. signed COBRA election form along with proof of premiums paid, etc.)

_____

If the specific claimant is a dependent, provide the following information:
Other Insurance:_____Date of Enrollment:_____
Effective Date:_____

_____Date:_____
(Authorized Employer Representative Signature/Title)

WARNING: *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*