Significa Benefit Services, LLC.
P.O. Box 7777
Lancaster, PA 17604-7777
Ph: 717-581-1300 Fax: 717-581-1319

EMPLOYER ELIGIBILTY VERIFICATION

Attention:	Date:
Employee Name:	
Claimant Name:	
Member ID/Social Security Number:	
Please complete the Employer Certification in reference to the above employee.	
This information is being requested in order to verify the employee or dependents eligibility in accordance with the group health plan. This request is for Treatment, Payment and Healthcare Operations as defined under HIPAA Privacy and is a permitted disclosure.	
Employer Name:	Group #:
Employer Address:	
Employee Occupation:	
Is injury or illness related to employment? ☐ Yes ☐ No	Date of Employment:
Effective date of Coverage:	Number of hours employee works per week:
Date employee ceased to work the minimum eligible hours per week:	
Reason: ☐ Terminated ☐ Leave of Absence ☐ Disabled ☐ Retired	

Regardless of claimant, please indicate any dates the employee was absent during this current plan year. Specify the dates of each absence and how eligibility was maintained:

	From:	To:	Total time used:
Sick leave used:			
Vacation time used:			
FMLA:			
Other:			

How is your FMLA leave administered? ☐ Calendar Year ☐ Fixed Year ☐ Rolling ☐ Leave Date_____
Date employee returned to work._____
If applicable were all employee contributions paid during leave? ☐ Yes ☐ No

I hereby certify that the above named employee was eligible for benefits under the group health plan at the time this claim was incurred and that the information contained in the employer statement is complete and accurate to the best of my knowledge.

_____ _____
Signature and Title of Official Representative Date

_____ _____
Employer Telephone Number with Area Code E-mail