

## Eligibility Questionnaire

Employee's Name:

Group Name:

***If you have received any out of work notes, FMLA paperwork, or any other certifying documents from the healthcare provider, please attach a copy. We may be able to use this information to complete our review.***

1. Date last worked 4 or more hours: \_\_\_\_\_ Number of hours worked on last day worked: \_\_\_\_\_
2. First day absent from work: \_\_\_\_\_
3. Estimated return to work date or actual date: \_\_\_\_\_
4. Date of hire: \_\_\_\_\_
5. Is the employee is currently eligible and enrolled in the VAcrop Hybrid Disability Plan offered by Anthem?  
Yes                      No
- If no, is the employee enrolled in the Legacy plan?                      Yes                      No
6. Effective date of enrollment in VRS: \_\_\_\_\_
7. Insurance effective date: \_\_\_\_\_
8. Is this person a contract employee?                      Yes - provide contract dates below                      No  
  
    Current contract start date: \_\_\_\_\_                      Next contract start date: \_\_\_\_\_  
  
    Current contract end date: \_\_\_\_\_                      Next contract end date: \_\_\_\_\_  
  
    125<sup>th</sup> Work Day (***please provide copy of Work Days Calendar***): \_\_\_\_\_
9. Occupation: \_\_\_\_\_
10. Standard work week hours: \_\_\_\_\_
11. Is claim work related?  
Yes - provide copy of Workers Compensation approval or denial letter                      No
12. If employee is able to return to work with restrictions, are you able to accommodate modified duty?  
Yes                      No

Notes: