Benefit Advantage
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DEPENDENT ELIGIBILITY

INTAKE FORM

PART 1: EMPLOYER INFORMATION

Company Name: ____________________

Address: ____________________

Phone Number: ____________________

Fax Number: ____________________

Contact Person: ____________________

Phone Number/extension: ____________________

Email: ____________________

Total Number of Employees: ____________________

Total on Health Plan: ____________________

Total of Single Coverage:

PART 2: DEPENDENT ELIGIBILITY INFORMATION

Total Process Time: ____________________

Start Date/Letter 1: ____________________

Letter 2 – i.e. 30, 45 or 60 days after letter 1: ____________________

Letter 3 – i.e. 15, 30 or 40 days after letter 2: ____________________

Consequences: ____________________

Amnesty Communication (if any): ____________________

Do you allow for any non-standard definitions of eligibility (i.e. domestic partner)? ____________________

List acceptable documentation for non-standard eligibility (i.e. signed affidavit). ____________________

Documentation due by: ____________________

Other Issues/Instructions:

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