

Employer Verification of Loss of Coverage SEP Validation Form



Purpose: To confirm whether an employee or dependent experienced a qualifying (involuntary) loss of employer-sponsored coverage for the purpose of determining eligibility for a Special Enrollment Period (SEP) in the individual market. Any application for individual coverage remains in a pending status and will not process until this validation is completed, reviewed, and approved by Sanford Health Plan. In addition, this form is required under a loss of employer sponsored coverage event to be completed and returned to Sanford Health Plan within 60-days of the event.

Who Completes It:

The employer or HR benefits administrator — *not* the employee.

Employer Information

- Employer name _____
- Employer address _____
- Employer EIN _____
- HR/benefits Contact Name _____
Phone Number _____ Email _____

Employee/Dependent Information

- Name of affected individual _____
- Relationship: Employee / Spouse / Dependent _____
- Last date of employer-sponsored coverage _____

Reason for Coverage Termination

- Termination of employment
- Reduction in hours resulting in loss of eligibility
- Employer ceased offering group health coverage to this employee class
- Employer plan terminated or was discontinued
- Loss of employer contribution toward premium (not due to employee nonpayment)
- Divorce or legal separation resulting in dependent loss of coverage
- Death of employee resulting in dependent loss of coverage
- Employee voluntarily canceled coverage
- Employee declined coverage during Open Enrollment
- Employee elected a different plan type (Coverage Tier or Plan Option)
- Employee failed to pay their portion of premiums
- Employee waived coverage for other insurance (e.g., spouse plan, Medicare)
- Other termination (explanation) _____

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Certification Statement

I certify that the information provided above is accurate to the best of my knowledge. I acknowledge that knowingly providing false or misleading information may constitute insurance fraud and may subject the employer and/or employee to penalties.

Printed Name Employer Representative _____

Signature Employer Representative/ Date Completed _____

Please return the completed form to use by one of the methods listed below:

Email - SHPBillingandEnrollment@SanfordHealth.org

Mail - PO Box 91110, Sioux Falls, SD 57109

Phone - (800) 752-5863