EMPLOYER'S STATEMENT

Employee's Name	Social Security Number	Date of Birth

Employee's Address	Occupation

A. Information About the Employer

Employer's Name	Employer's Phone Number

Employer's Address	Employer's Fax Number

Name and Address of Location where Employee Works	Location Telephone Location Fax

B. Information About the Employee

Employee's Hire Date	Date Employee became insured under this plan: Date Employee became insured under prior plan:	No. of hours Employee regularly works per day/per week _____# of hours/week _____# of hours per/day

C. Information About the Claim

Before Employee became fully disabled, were changes made to Employee's job responsibilities due to the disabling condition?

_____Yes _____NO If **Yes**, please describe the changes and when they were made.

Date Employee Last Worked	Did Employee work a full day? _____Yes _____NO If **NO**, how many hours were worked?

What was Employee's permanent job on his/her last day worked?	How long had Employee been in this job?

Why did Employee stop working?	Has Employee returned to work? _____Yes _____No If **Yes**, when?

Is Employee's condition work related? _____Yes _____No	Has a Workers' Compensation claim been filed? _____Yes _____No If **Yes**, send initial report of illness/injury and award notice

Name of Workers' Comp Carrier	Address of Workers' Comp Carrier	Contact Person's Name & Phone Number

Name and Address of Medical Insurance Carrier	Is Employee covered under a Group Life Policy? _____Yes _____No

D. Leave Information and Salary

Employee Received Sick Pay From _____ To _____ Amount $_____

Employee Received Vacation Pay From _____ To _____ Amount $_____

Employee's Current Annual Salary $_____ Effective: _____

Employee's Current Bi-Weekly Salary $_____ Approximate Date Employee will return to work: _____

Employer's Signature	Print

Title	Date

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