Employer Statement
Certification for Disability Benefits

Instructions: ***Please complete this form and return to our office as soon as possible. This form must be on file in order to issue disability benefits to the employee.***

Employee Name:___________________________________Member ID: ___________________

Employer Disability Premium Contribution___________%
(If this information is incorrect, please indicate current employer disability contribution______%)

Does the employee make a premium contribution through a “pre-tax: program? □ Yes □ No

Employee Occupation: ____

Base Earnings: _____________ ___ per year ___ month ___ week (Check one)

Is this disability due to work related injury? □ Yes □ No

Has employment been terminated? □ Yes □ No

If yes, give reason and date of termination:

____

____

Please provide W-4 form on file

Date employee last worked:_____/____/____ Date returned to work:____/____/ ___

Date employee expected to return to work: ___/____/ ___

Name and Address of Employer:

____

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Signature: _____________________________________ Date: ___________________________

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