

Equitable
C/O Maxon Administrators, Inc.
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EMPLOYER'S STATEMENT (Please Print or Type)

Employer's Name: _____

Employer's Tax Identification No.: _____

Policy Number: _____

1. Employee's Full Name: _____ Social Security Number: _____

2. Employee's Address: _____

3. Date of Birth: _____

4. Employee's Occupation: _____ Date of Hire: _____ Status: Full Time ___ Part Time ___

5. Is Claimant: an employee ___ an owner ___ a high school student ___

6. Is Employee a Union Member: YES ___ NO ___ Check Days Normally Worked: Mon ___ Tues ___ Wed ___ TH ___ Fri ___ Sat ___ Sun ___

7. Date Employee Last Worked: _____

8. Date Employee's Wage Ceased: _____

9. Date Employee Returned to Work: _____

10. Are you paying wages or sick time: YES ___ NO ___

If yes, time period paid: _____ Is Reimbursement Requested: YES ___ NO ___

11. Is Disability due to job: YES ___ NO ___

If so, has a compensation claim been filed: YES ___ NO ___

12. Reason if the employee is no longer employed: _____ Date terminated: _____

13. Is the Employee receiving or claiming unemployment insurance: YES ___ NO ___

14. Has the employee received DBL or PFL benefits within the past 52 weeks: YES ___ NO ___

If yes, provide dates: _____

Percentage of weekly disability premium paid by employer: _____

If blank we assume the Employer pays 100% of the premium

EARNINGS FOR 8 WEEKS PRIOR TO LAST DAY WORKED				
MONTH	DAY	YEAR	# OF DAYS WORKED	GROSS AMOUNT
TOTAL				\$

CONTACT INFORMATION:

Employer Address: _____

Phone: _____ Fax: _____ E-mail: _____

Print Name: _____ Sign: _____

Title: _____ Date: _____