AXA Equitable Life Insurance Co. C/O Maxon Administrators, Inc.

PO Box 606

Neversink, NY 12765

EMPLOYER'S STATEMENT (Please Print or Type)

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 ☐ employee ☐ owner ☐ 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. Has the employee received DBL or PFL benefits within the past 52 weeks? YES ☐ NO ☐
    If yes, provide dates_____

Employer's Name_____

Employer's Tax Identification No. _____

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	$

EMPLOYER INFORMATION:

Employer Name: _____

Employer Address: _____

_____

Phone: _____ Fax: _____ E-mail _____

Print Name _____ Sign _____

Title _____ Date _____