Equitable
C/O Maxon Administrators, Inc.
PO Box 606
Neversink, NY 12765

Tel#: (800) 999-3309
Fax#: (845) 985-0238
Email: disability@maxonco.com

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: _____