EMPLOYER'S CLAIM STATEMENT

Please complete both pages of this form, sign and date and return it to:
New York Life Insurance Company
Group Membership Association Disability Claims
PO Box 228
White Plains, NY 10602

Employee Name**:** _____ Social Security No**.** _____-____-_____

Name of Employer: _____

Employer Address: _____

_____

Date the employee was hired: ____/_____/_____ Date the employee last worked: _____/_____/_____

No. of hours worked per week: _____ If less than 30 hours, date employee began this schedule: ____/____/____-

Has employee returned to work? ☐Yes: ☐ No: If "Yes": Date: _____/_____/_____

Day(s) per week: _____

Hours per day: _____

Average Monthly rate of pay prior to last date worked: $ _____

Average Monthly rate of pay for the 2 years prior to last date worked: $ _____ _____ Year

$ _____ _____ Year

Please check a box for each of the following benefits, which the employee, to your knowledge, is receiving or entitled to receive. Feel free to attach additional pages if necessary.

Salary continuance No ☐ Yes ☐

$ _____ per _____ From:_____/____/_____ Through:____/____/_____

Group Short Term Disability No ☐ Yes ☐

If "Yes"" Policy No.: _____

Carrier Name and address: _____

_____

_____

Group Long Term Disability No ☐ Yes ☐

If "Yes"" Policy No.: _____

Carrier Name and address: _____

_____

_____

Employee Name: _____

Social Security Number _____-____-____

Workers' Compensation

Did this disability occur as result of the claimant's employment? ☐Yes ☐No ☐In dispute

If "Yes" or in dispute, please indicate the Name, Address and Telephone number of the Workers' Compensation Administrator as well as the Policy No.:

_____

_____

_____

Workers' Compensation No ☐ Yes ☐ $ _____ per _____

From _____/_____/_____ Through _____/_____/_____

Civil Service Retirement Annuity No ☐ Yes ☐

If "Yes" Benefit Amount $ _____ Effective Date: _____/_____/_____

PLEASE ATTACH A COPY OF THE EMPLOYEE'S JOB DESCRIPTION.

_____/_____/_____ By: _____
MO. DAY YR., Authorized Signature

Telephone No.: (____) _____ _____
Print or Type Name

Fax No.: (_____) _____