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NATIONAL BENEFIT LIFE INSURANCE COMPANY

PO BOX 1946, Long Island City, N.Y. 11101 ▪ TEL 1-800-535-2710 ▪ FAX 1-800-584-9303

NOTICE TO EMPLOYER

EMPLOYEE ______________________
SSN # ______________________
CLAIM # ______________________
POLICY # ______________________

Your employee or former employee has submitted a claim for New York State Disability Benefits. In order to properly process the claim, and in accordance with the New York State Disability Benefits Law, employers are required to provide a statement on behalf of any individual who has applied for benefits.

Your cooperation in completing and returning this form promptly will assist us in determining the employee's eligibility for Disability Benefits.

PLEASE PRINT OR TYPE

1. Employee's Name ______________________
2. Address ______________________ Zip ____________
3. Date of Employment ______________________ Occupation? ____________
4. Actual last date employee worked prior to disability ______________________
5. If employee has returned to work give date of return ______________________
6. If not yet returned to work, do you expect to rehire? ☐ YES ☐ NO
7. Date wages ceased ______________________
8. Are wages being continued during disability? ☐ YES ☐ NO
9. If yes, is reimbursement requested? ☐ YES ☐ NO
10. On what date did you receive the completed claim form? ____________
11. Did disability occur as a result of employment? ☐ YES ☐ NO
12. Name of your Workers' Compensation Carrier ______________________
13. Employees' wages for last eight weeks **worked** prior to

WEEK NO.	(WEEK ENDING) MO.	DAY	YEAR	NUMBER OF DAYS WORKED	GROSS WAGES	WEEK NO.	(WEEK ENDING) MO.	DAY	YEAR	NUMBER OF DAYS WORKED	GROSS WAGES
1					$	5					$
2						6					
3						7					
4						8					

14. If employee received extras such as tips, board, meals, etc., state reported weekly value: $ ____________
15. Employee's usual days worked: ☐ MON. ☐ TUES. ☐ WED. ☐ THURS. ☐ FRI. ☐ SAT. ☐ SUN. ☐ PART TIME ☐ FULL TIME
16. Has employee claimed disability benefits in the past 52 weeks? ☐ YES ☐ NO If yes, date ____________
17. Is claimant an ☐ employee ☐ owner ☐ co-owner ☐ partner ☐ proprietor ☐ spouse of employer?
18. Is employee presently a full-time high school student? ☐ YES ☐ NO
19. If employee is no longer in your employ, check reason for separation : Labor dispute ☐ Lack of work ☐ Fired ☐ Quit ☐
20. If employee was fired or quit state reason ______________________ Date ____________
21. Has the claimant received U.I. Benefits? ☐ YES ☐ NO If yes, give dates: ____________
22. Is employee a member of a union which provides disability benefits? ☐ YES ☐ NO

    If yes, indicate name and address of union ______________________

23. **IMPORTANT** ___ Indicate percentage employee contributes to premium ____________ %

IMPORTANT- COMPLETE THIS SECTION IN FULL

Employer ______________________
(Business Name)

Signature ______________________ **Title** ____________

Disability Benefits
Policy No. 8-910 ______________________

Phone No. ______________________

ADDITIONAL COMMENTS

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