STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
DISABILITY CLAIMS DEPARTMENT

P.O. Box 25339 • Farmington, New York 14425-0339

PHONE 1 (585) 398-2340 * FAX 1 (585) 398-2854 * E-MAIL CLAIMS@SSLICNY.COM

REQUEST FOR EMPLOYMENT AND WAGE VERIFICATION

1. Employee's Name _____
2. Employee's Address _____
   _____
3. Employee's Occupation _____Employee's Date of Birth_____
   Date Employed _____ 19 _____or 20 _____ SS#
4. ❑ Full time ❑ Part
   Check usual days worked | MON | TUE | WED | THUR | FRI | SAT | SUN |
5. Is claimant an ❑ Employee ❑ Owner ❑ Partner ❑ High school student
6. Date employee **last worked** (**NOT** last date paid) _____ 20_____
7. Date employee's salary continuance/sick time (NOT vacation pay) ceased :_____ 20_____
8. Date employee returned to work _____ 20_____ 8a. Planned return date_____
9. Is **salary continuance** or **sick time** being paid during disability? ❑ Yes ❑ No
10. If "Yes", is reimbursement requested? ❑ Yes ❑ No
11. On what date did you receive the completed claim form? _____
12. Did the disability occur as a result of employment? ❑ Yes ❑ No
13. Name and address of your Compensation carrier _____
    _____
14. Do you expect to rehire? ❑ Yes ❑ No
15. Is employee a member of a union, which provides New York State Disability Cash Benefits? ❑ Yes ❑ No
16. If employee is no longer in your employ, check reason
    ❑ Labor dispute ❑ Lack of work ❑ Fired ❑ Quit
17. Has the claimant received U.I. Benefits? ❑ Yes ❑ No
    If "Yes", give dates _____ 20 _____

EARNINGS FOR 8 WEEKS PRIOR TO LAST DAY WORKED

MONTH	DAY	YEAR	# OF DAYS WORKED	GROSS AMOUNT

Indicate weekly value of board, lodging and tips
TOTAL
$ _____

POLICY # _____

Employer's Name
_____
Address _____
_____
Date _____ Telephone _____
Fax_____
Signed by _____
Title _____
E-Mail:_____

-- IMPORTANT --
Indicate percentage employee contributes to premium _____%
(If blank or not a %, we will tax at 100%)