

# Employer Statement Certification for Disability Benefits

Instructions: **Please complete this form and return to our office as soon as possible. This form must be on file in order to issue disability benefits to the employee.**

Employee Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

Employer Disability Premium Contribution \_\_\_\_\_ %  
(If this information is incorrect, please indicate current employer disability contribution \_\_\_\_\_ %)

Does the employee make a premium contribution through a "pre-tax: program?  Yes  No

Employee Occupation: \_\_\_\_\_

Base Earnings \$ \_\_\_\_\_ Per year/month/week (Circle one)

Is this disability due to work related injury?  Yes  No

Has employment been terminated?  Yes  No

If yes, give reason and date of termination:

**Please provide W-4 form on file**

\_\_\_\_\_

Date employee last worked: \_\_\_ / \_\_\_ / \_\_\_ Date returned to work: \_\_\_ / \_\_\_ / \_\_\_

Date employee expected to return to work: \_\_\_ / \_\_\_ / \_\_\_

Name and Address of Employer:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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